REPORT

ON THE

INVESTIGATION OF MEDICAL ATROCITIES AND MALPRACTICES COMMITTED BY U.S. ARMED FORCES IN KOREA

ON

SICK AND WOUNDED CHINESE PEOPLE'S VOLUNTEERS PRISONERS OF WAR

THE RED CROSS SOCIETY OF CHINA
Peking

OCTOBER 1953

CONTENTS

CHAPTER I

INTRODUCTION

Upon the signing of the Agreement for the Repatriation of Sick and Injured Captured Personnel on April 11, 1953, at Panmunjom by both sides to the Korean armistice negotiations, the first group of sick and wounded captured personnel of the Chinese People's Volunteers returned to their motherland. When they were most heartily welcomed and comforted by their compatriots, they complained most bitterly against the horrible treatment and the lack of adequate medical care for their sicknesses and injuries during their captivity in the U.S. P.O.W. camps.

After the Korean Armistice Agreement was signed on July 27, another group of sick and wounded Chinese People's Volunteers came home early in August. The majority of this group should have been repatriated in April, but the U.S. side in violation of the agreement detained them for three to four months. Among the repatriated P.O.W.s who were not classified as sick and wounded, 107 were found to have various diseases and injuries, and therefore had to be hospitalized together with the sick and wounded. The total number of the two groups of persons examined was 1,609.

In order to solve the health problems of our sick and wounded repatriates, the Red Cross Society of China invited a number of experienced and well-known specialists in various branches of medicine to investigate into the health conditions of the repatriates.

The nutritional conditions of the returned P.O.W.s were in general very poor. For this reason, we examined a group of 1,045 non-sick-and-wounded repatriates, who returned in early August, in order to investigate thoroughly into their general nutritional status so that adequate measures might be suggested for the early restoration of their health.

Among the 1,609 sick and wounded, there were 1,172 surgical cases and 567 medical cases, including 225 classified in both categories. The remaining 95 cases were of miscellaneous nature including 35 psychiatric cases.

Of the 1,172 cases of surgical injuries, as many as 840 have been incapacitated or crippled. There are at least 98 cases whose disablement was chiefly due to wrong amputations by the U.S. medical personnel, for which the U.S. side must bear full responsibility. In numerous instances, the treatment of wounded prisoners of war given by the U.S. medical personnel was against the basic principles of medicine. From the present plight of these returned P.O.W.s can be traced the intentional and criminal nature of the malpractices committed by the U.S. medical personnel.

Almost all the 567 patients with medical conditions are suffering from protracted chronic diseases. Aside from 31 cases with digestive disorders and 14 with miscellaneous illnesses, the great majority (92 per cent) have chronic diseases of the respira-

tory system, 230 tuberculous and 292 non-tuberculous. From the study of these cases one can visualize the horrible living conditions in the U.S. P.O.W. camps. These cases prove conclusively that brutalities and persecutions have been perpetrated by the U.S. armed forces.

Detailed accounts of our investigations are given in the following chapters of this Report.

CHAPTER II

BONE AND JOINT INJURIES

Among the 1,172 wounded returnees, 637 had bone and joint injuries involving 710 limbs. After careful investigation of the treatment they received for their injuries during the period of their captivity, we have found that the American military surgeons committed inexcusable errors in the management of the war wounds. These errors can be grouped under the following categories:

1. No proper initial operative treatment.
2. Inadequate immobilization or no immobilization of fractures.
3. Failure in reduction of fractures.
4. Malpractised manipulation causing refractures.
5. Unreasonable amputations.

1. No Proper Initial Operative Treatment

Of the 710 limbs with compound bone and joint injuries, 81 were excluded for analysis either because the wounded soldiers had treatment before they were captured or because they were unconscious at the time of capture so that the nature of the initial treatment could not be satisfactorily ascertained. In the remaining 629 limbs, only 214 (34 per cent) received operation within seven days after capture. The other 415 limbs (66 per cent) did not receive any initial operative care.

ILLUSTRATIVE CASE 1: RECORD NO. 146, LIU WEN-TS'AI (ALIAS, LIU WEN-HSI), I.S.N. (Internment serial number) 730247 Received a shell wound of the right foot on March 3, 1951, and was captured twelve hours later. The wound was dressed. No transportation fixation. No treatment at all for the following six days. Plaster-of-Paris bandage was applied three days after arriving at Pusan American Base Hospital.

The wound was badly infected, and the fourth and fifth toes had to be excised. In May, 1951, while the remaining toes were still in comparatively good condition, the American military surgeons proceeded to amputate the right foot through the ankle region. Later, the stump was re-amputated through the lower third of the leg.

Comment: In this case, the patient was captured only twelve hours after injury. It was an optimal time for debridement, but the American military surgeons neither performed the operation, nor applied fixation in the forward area before transporting him to Pusan. Even in Pusan Base Hospital no surgery was performed and only a simple plaster cast was applied after another delay of three days. It was quite natural for infection to spread. Later, instead of controlling infection by other surgical means, amputation was resorted to without proper indication.

2. Inadequate Immobilization or No Immobilization of Fractures

It is an accepted principle that all bone and joint injuries of the extremities should be immobilized before the wounded are transported. Immobilization is particularly

essential in injuries of the lower extremity. In this group of returnees fractures of the lower extremities occurred in 483 limbs. No immobilization of any kind was applied during transportation in 210 instances (43.5 per cent). Even in the Pusan American Base Hospital of the rear zone, immobilization for fractures was usually delayed and in a large number of cases the immobilization was inadequate. In this whole series of 710 limbs with compound fractures, there were 175 instances in which the fixation was either inadequate or totally lacking.

ILLUSTRATIVE CASE 2: RECORD NO. 450, LIN TAI-HSIEN, I.S.N. 706463. Shell wounds of left ankle and right heel, May 22, 1951. Wounds dressed by himself. Was captured two and a half days later. Initial surgery and immobilization were done. The wound of the left ankle soon became infected and heavily infested with maggots. Incision and drainage was carried out, but no immobilization was given after this operation. Twenty days following the operation, he was forced to get out of bed and walk. The injured ankle was then strained. Thereafter, he had to be confined to bed, still without any immobilization of the leg and foot. Two months later, he was ordered to walk again which made the wound worse. Subsequently, two more operations were performed for drainage. During all this time the ankle was never immobilized. It was left for deformity to develop as shown in Fig. 1.*

Comment: Proper immobilization in the treatment of the compound fractures of bones and joints is one of the well-known fundamental surgical principles. Complete negligence of this principle on the part of American military surgeons in the treatment of this case is inexcusable.

ILLUSTRATIVE CASE 3: RECORD NO. 1366, YEN TUNG-SHAN (ALIAS, YIN TUNG-SHENG), I.S.N. 706353. Received a gunshot wound in the left lower leg on January 11, 1951. No debridement was performed after capture. The wound was simply dressed and a short leg cast was applied. On reaching Pusan Base Hospital, he received no more treatment. The short cast was left in place for two months, after which it was removed for change of dressing. The wound was infested with maggots. On August 10 of the same year, sequestrectomy was done, but no cast was applied. This returnee

* All of the photographs in this report were taken two to three months after repatriation.

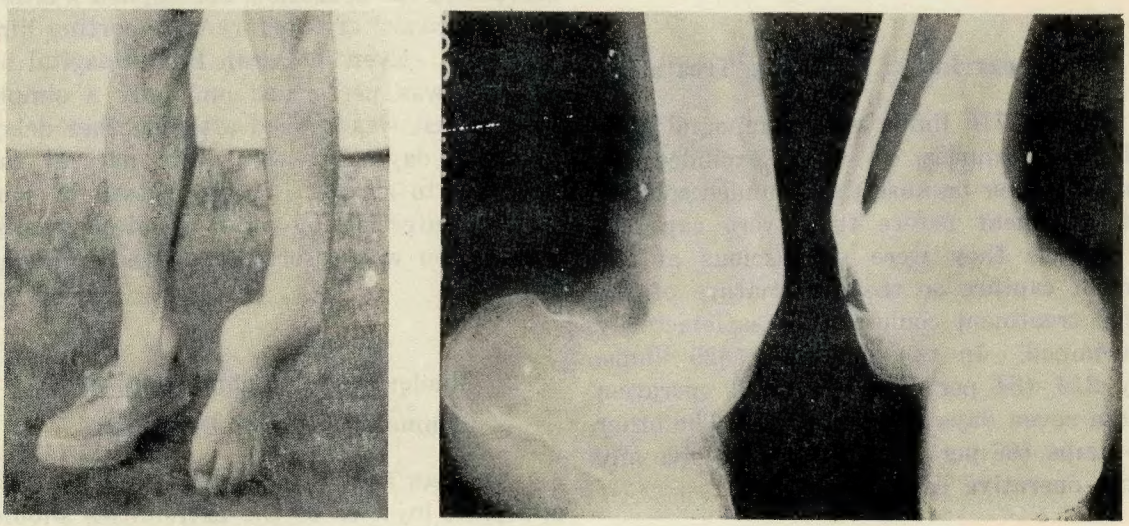


Fig. 1. Case 2. Showing deformity of right foot and leg due to malunion following inadequate immobilization.

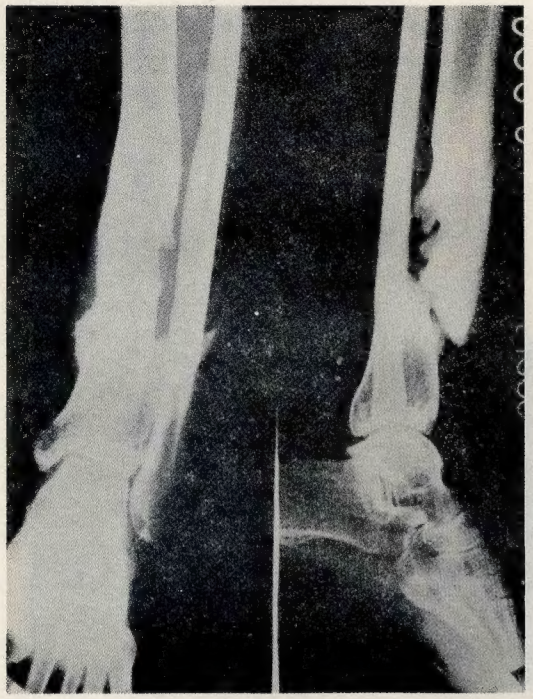


Fig. 2. Case 3. Roentgenogram showing non-union of fracture of lower third of left tibia due to infection and inadequate immobilization.

has at present an ununited fracture of the right tibia (Fig. 2).

Comment: In this case, failure in carrying out proper initial operative treatment predisposed the development of infection of the wound. To immobilize a fractured leg with a short leg cast was inadequate and the period of fixation (two months) was also too short. All these resulted in serious and prolonged disability due to non-union of the leg fracture. For all these gross errors, the American military surgeons must be held responsible.

ILLUSTRATIVE CASE 4: RECORD NO. 573, LIU YU-CHUN, I.S.N. 706417. Received gunshot wound of the right arm in May, 1951, and was captured three hours after being wounded. Operation was performed in the forward area on the following day. Afterwards, the arm was fixed to the chest with plaster-of-Paris bandage with the elbow in a right angle. At Pusan Base Hospital, the cast was not removed until two months later. Since then, he has not been able to abduct the right shoulder.

Comment: The thoraco-brachial cast is a type of temporary fixation used only for evacuation, but the American military surgeons at the Pusan Base Hospital allowed it to stay on throughout the course of treatment. This improper immobilization undoubtedly caused adduction contracture of the shoulder, and the returnee's disability.

3. Failure in Reduction of Fractures

Among the 637 cases of bone and joint injuries, only 43 healed without disability. Eleven cases are still under treatment and the result can not at present be appraised. Of this total, 583 cases are more or less disabled. Among them there are 231 cases with malunion. Poor results as observed in these cases have led us to doubt if the American military surgeons intended at all to reduce the fractures. The following roentgenograms of some of the fracture cases among the returnees will help one to see what American military surgeons did with these fractures:

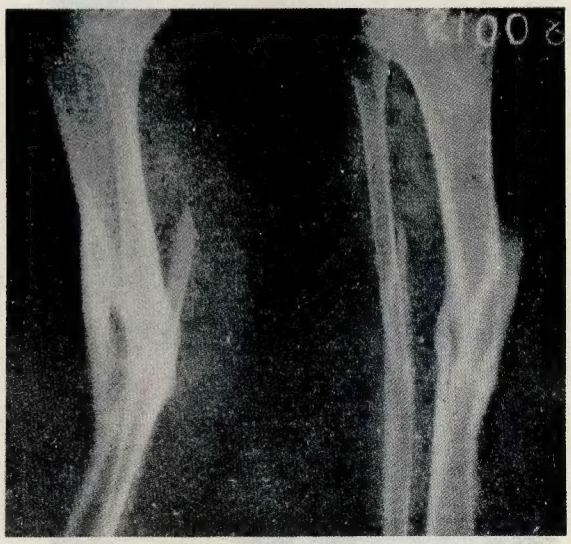


Fig. 3. (Record No. 1561, I.S.N. 733151) Malunion of middle third of right tibia and fibula with marked posterior bowing.

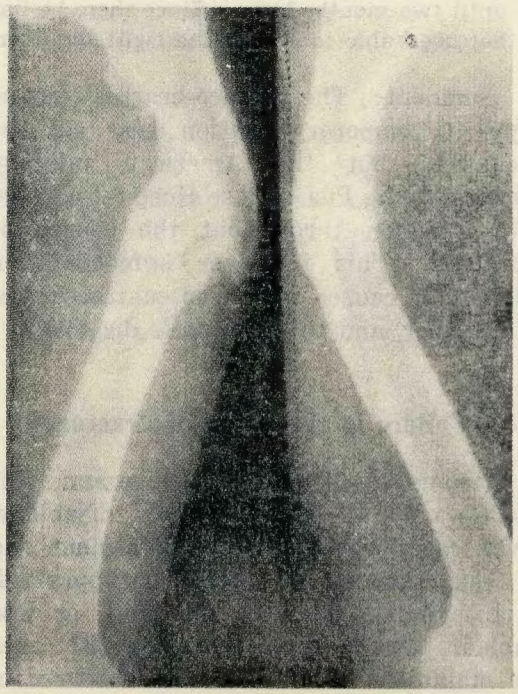


Fig. 4. (Record No. 1247, I.S.N. 706375) Angulation and malunion of the fracture of femur treated with the same cast through the period of immobilization.

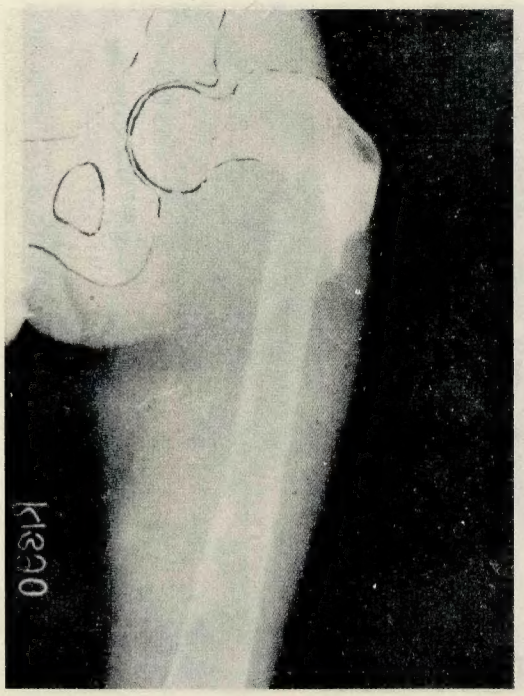


Fig. 6. (Record No. 1930, I.S.N. 732967) Malunion of fracture of the upper end of femur, resulting from lack of reduction.

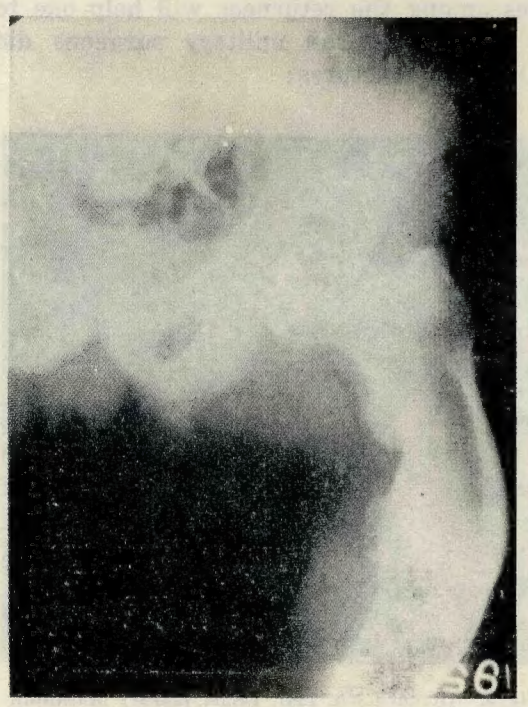


Fig. 5. (Record No. 1241, I.S.N. 730237) Marked bowing of the femur.

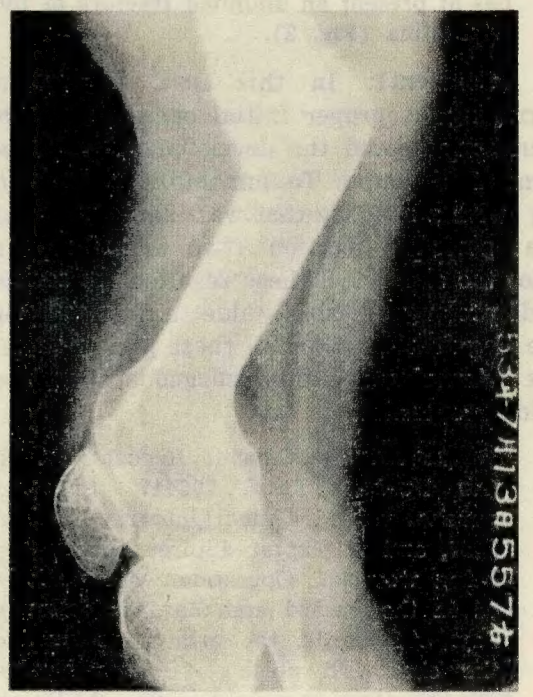


Fig. 7. (Record No. 557, I.S.N. 732970) Malunion of right femur.

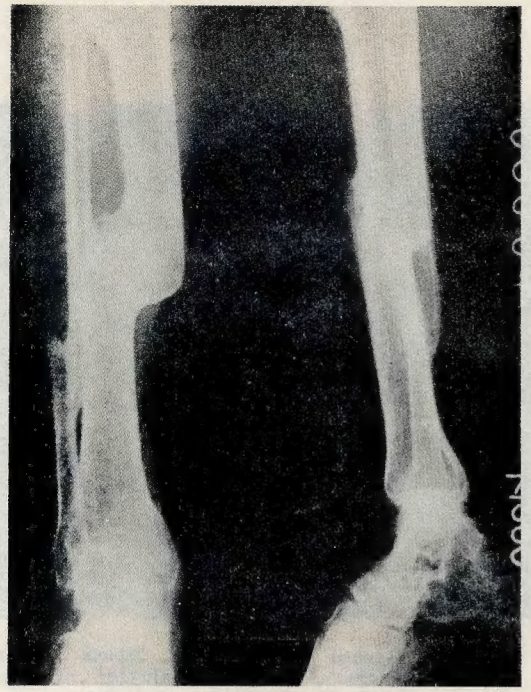


Fig. 8. (Record No. 1395, I.S.N. 707486) Malunion of fractures of right tibia, resulting from lack of proper reduction.

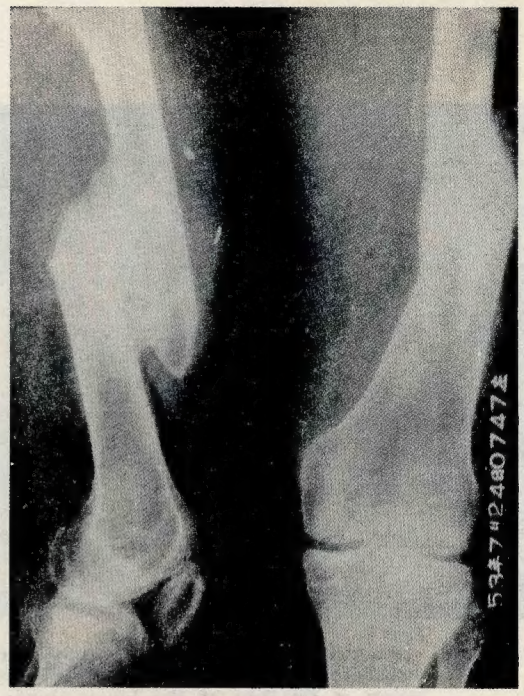


Fig. 10. (Record No. 188, I.S.N. 730725) Roentgenogram showing malunion of compound fracture of femur resulting from lack of proper reduction.

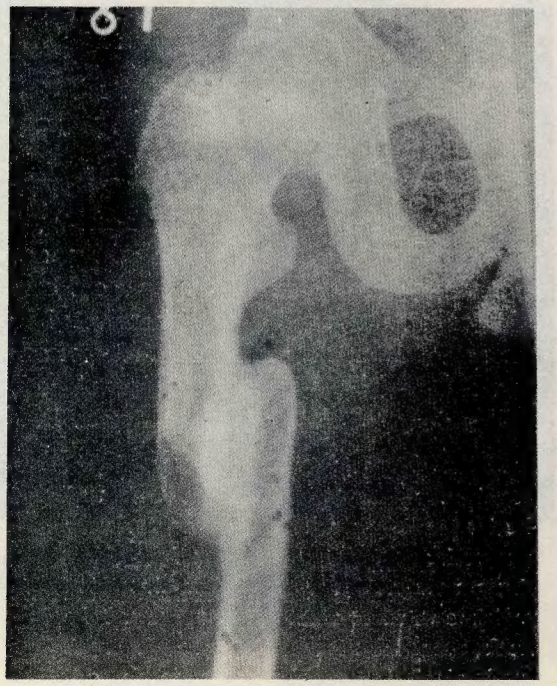


Fig. 9. (Record No. 1546, I.S.N. 731209) Malunion of upper third of right femur.

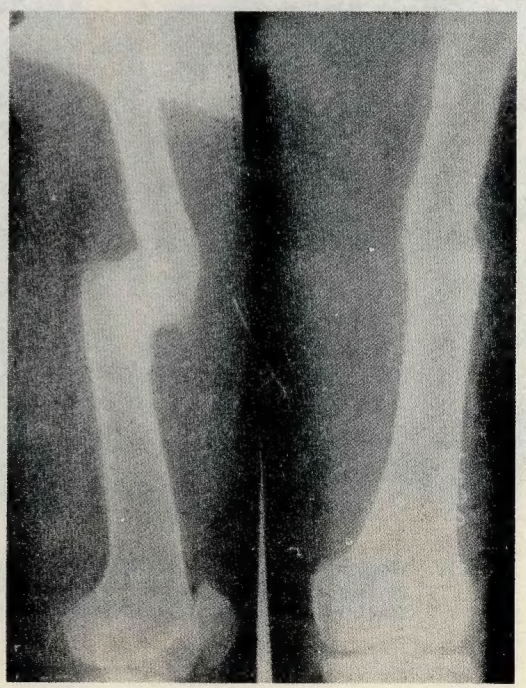


Fig. 11. (Record No. 1433, I.S.N. 707449) Malunion of middle third of left femur.

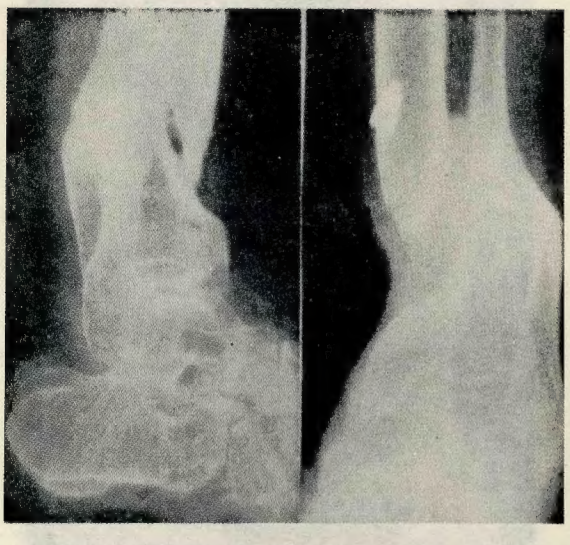


Fig. 12. (Record No. 538, I.S.N. could not be remembered) Roentgenogram showing malunion of fracture of the lower third of tibia and fibula, left.

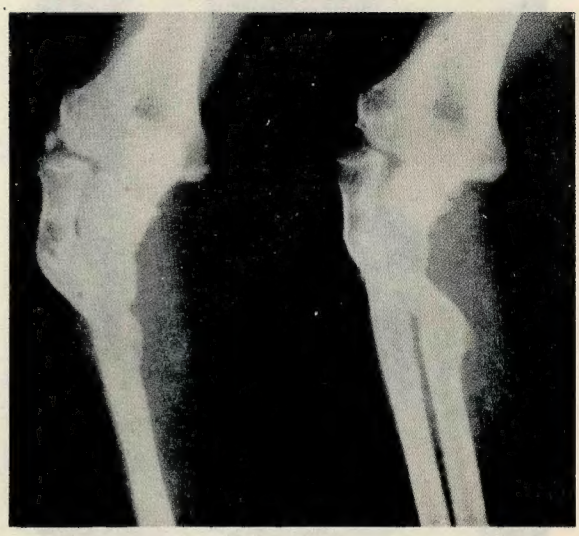


Fig. 14. (Record No. 53, I.S.N. 780068) Roentgenogram showing malunion of upper third of right ulna and radius.

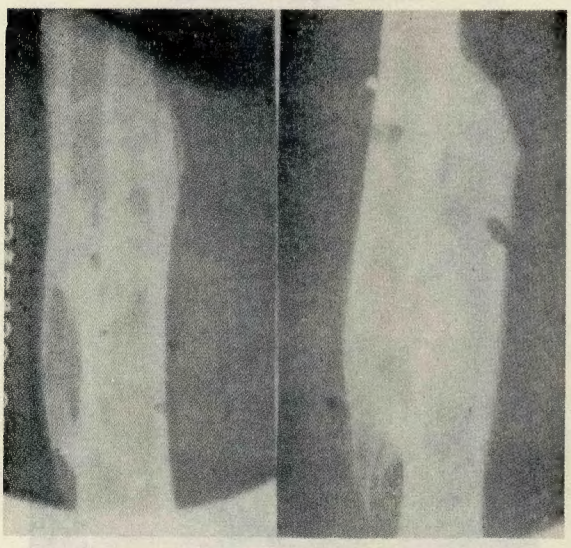


Fig. 13. (Record No. 194, I.S.N. 731028) Roentgenogram showing marked overriding of fracture of middle third of right femur.

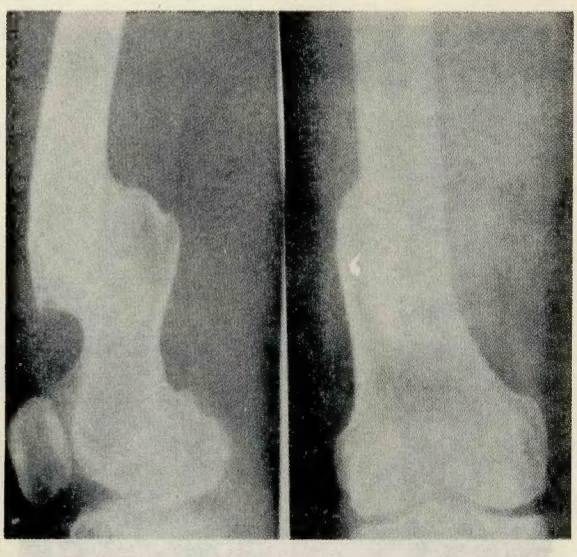


Fig. 15. (Record No. 670, I.S.N. 706366) Roentgenogram showing malunion of lower third of right femur.

Of the 153 femur fractures, 130 (85.0 per cent) received no suspension traction. Internal fixation was used in seven cases, and some sort of traction treatment was attempted in 16 cases, but even in these cases many errors were committed.

ILLUSTRATIVE CASE 5: RECORD NO. 51, KAO YUN-CH'ENG, I.S.N. 730215. Received a shell wound of the left foot on May 21, 1951, and was captured five days afterward. At Pusan, the dressing was changed and a plaster-of-Paris cast was applied. The wound healed in six months.

On October 1, 1952, in the P.O.W. camp on Cheju Island, he sustained a gunshot fracture of the right femur when he was intentionally shot by an American soldier. He was sent to the Pusan Base Hospital. Excision of the wound was carried out and a hip spica cast was applied. No attempt was made to reduce the fracture. Now, his right leg is 5.5 cm shorter than the other side with marked angulation (Fig. 16).

Comment: In general, suspension traction is essential in the treatment of fractures of femur in order to maintain reduction. In an article entitled: Care of Battle Casualities and Injuries Involving Bones and Joints, by M. Cleveland, J. C. Manning and W. J. Stewart, in the *Journal of Bone and Joint Surgery*, 33-A, No. 2, April 1951, quotation reads as follows:

"Section C.

Therapy in Communication Zone Installations (General hospitals and Station hospitals).

vi compound fractures.

* * *

2. Reduction and Immobilization.

a. Fractures of the long bones: Fractures of the femur, tibia and fibula and of the humerus will be treated by skeletal

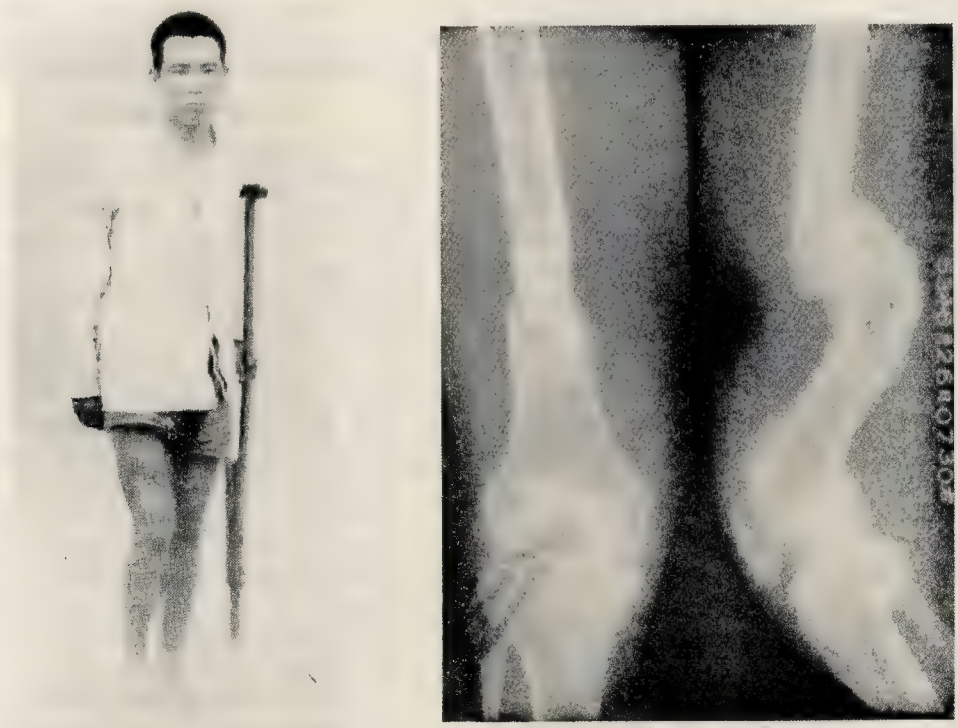


Fig. 16. Case 5. Gunshot fracture of right femur, treated without traction or other measures for reduction. The result was 5.5 cm shortening of the leg and marked angulation of the femur.

traction in every instance where it is possible to achieve a beneficial result within a reasonable length of time. Skeletal traction will be maintained until the position of the fragments has become sufficiently stable so that they will not displace or angulate...."

This case shows that the principle laid down by themselves has been ignored.

ILLUSTRATIVE CASE 6: RECORD NO. 648, KAO CH'I-FANG, I.S.N. 730269. Gunshot wound in the right thigh with compound fracture of lower third of femur on May 28, 1951. A plaster-of-Paris hip spica with a pin passed through the heel and incooperated into the cast was applied on June 1 at Pusan. The pin was removed two weeks later and the cast was removed 70 days afterwards. Present examination shows that the right lower extremity is 5 cm shorter than the left and the knee joint is stiff.

Comment: This case illustrates the erroneous type of traction that was employed. Apparently the reduction could not be successful.

ILLUSTRATIVE CASE 7: RECORD NO. 519, CHANG YING, I.S.N. COULD NOT BE REMEMBERED. Gunshot wound of right thigh with fracture of femur on October 3, 1952. Debridement was performed and a plaster-of-Paris hip spica was applied in the forward area. Secondary suture was done in the first part of November at Pusan. On the very day when the sutures were removed (10 days after the secondary suture), open reduction and internal fixation with plates and screws was carried out. This operation resulted in severe infection and osteomyelitis has persisted up to the present (Fig. 17).

Comment: To do an open reduction and internal fixation on a war fracture before infection is fully under control is against the basic principle of war surgery. The operation as was done in this case was therefore wrongly indicated.

Fig. 17. Case 7. Roentgenogram showing extensive osteomyelities and non-union ten months after an unjustified open reduction and internal fixation for compound fracture of right femur.

4. Malpractised Manipulation Causing Refractures

ILLUSTRATIVE CASE 8: RECORD NO. 1277, KENG CHAO-T'ING, I.S.N. 706268. Sustained gunshot wound of right arm in February, 1951. Was captured on the day he was wounded. Debridement and plaster-of-Paris shoulder spica were done in the front area. The cast was changed three days after he arrived at Pusan Base Hospital. Upon removal of the cast three months after the original injury, the fracture was found to have healed, but the elbow joint was stiff. Five days later, his elbow was manipulated. He was held down by three people while his stiff elbow was forcibly extended by a fourth person. During the process of this painful performance, the right arm suddenly yielded with a cracking sound. Marked swelling and excruciating pain developed in the arm, which subsided gradually only after more than ten days. A new plaster-of-Paris cast was applied after another x-ray examination.

Fig. 18. Case 8. Refracture of the middle portion of the right humerus resulted from malpractised manipulation of the elbow joint. The present roentgenoram shows the site of the fracture.

The cast was kept in place for more than two months afterwards.

Comment: For the correction of stiffness of joints following prolonged immobilization, active exercise and not forcible manipulation should have been prescribed. Any manipulation that is indicated should not be done with force. This is especially so with the elbow and the knee joints. The American military surgeons had completely ignored this principle in this case. That this error was not a mere accident is shown by the fact that there are five other similar cases in the series. Refractures were in the humerus in two cases and in the femur in the four other cases.

5. Amputation Employed as Primary Treatment for Bone and Joint Injuries

ILLUSTRATIVE CASE 9: RECORD NO. 152, NIEH MING-YIN (ALIAS, NIEH TING), I.S.N. 780077. Was captured one hour after shell wound of the right leg with fracture and traumatic amputation of three toes. Four hours later, i.e., five hours after injury, he was operated upon. Before the operation, he noticed that the color of his right foot was not much changed and motion of the ankle joint was free. When he recovered from anesthesia, he found that his leg was gone.

Comment: This is one of the many cases in which amputation was employed as the first and immediate treatment for bone and joint injuries without indication such as gas gangrene or injury of major blood vessels. This problem will be analysed in detail in Chapter IV. Among the total number of 637 cases of bone and joint injuries, major amputations of limbs were performed in 128 cases. The high incidence of amputation in the treatment of this group of war injuries is appalling and to resort to amputation without the trial of other conservative means is an even more inexcusable malpractice of surgery by the American military surgeons.

Recapitulation

1. Sixty-six per cent of 637 cases of bone and joint injuries did not receive proper primary operative treatment.

2. Forty-three and a half per cent of 493 cases of compound fracture of lower extremities had no transportation splintage.

3. Of the entire series of 637 cases of bone and joint injuries, examination of the condition of the injured parts was possible in 509 cases (128 cases in which amputation of the limb had already been done being excluded). Marked deformity was present in 231 cases (45.4 per cent).

4. Eighty-five per cent of 153 compound fractures of femur received no traction treatment.

5. Malpractised manipulation of stiff joints caused refractures in six cases.

6. Major amputations were done in 128 (traumatic amputations were excluded) out of 637 cases of bone and point injuries (20 per cent).

CHAPTER III

FROSTBITE

Among the 1,172 wounded returnees there are 139 cases which were treated for frostbite in the Pusan Base Hospital of the American armed forces and in which amputations were performed upon 283 limbs, constituting about a half of the total number of amputation stumps among all the returnees. This fact indicates that frostbite was not only prevalent but also that it gave rise to serious consequences. This situation, therefore, calls for a detailed investigation. The result of this investigation reveals some very significant facts which serve to indicate the nature of medical care rendered to the Chinese prisoners of war in the American army camps.

Of the 139 frostbite cases, six have to be excluded because of the presence of other major war injuries in the same limbs. This leaves 133 cases for analysis. Involved in these 133 cases are 276 limbs. Among the 276 limbs there are 14 complicated by minor war injuries that could not influence the indication of treatment of frostbite and are therefore included in this investigation (Table 1).

TABLE 1. NUMBER OF CASES OF FROSTBITE AND LIMBS INVOLVED AMONG 1,172 WOUNDED RETURNEES

	Frostbite	*Frostbite with major war wound*	*Total*
Number of cases	133	6	139
Number of limbs	276*	7	283

* Including 14 limbs with minor war wounds.

Data concerning these 133 cases are analysed from the following two aspects:

1. Treatment of Frostbite and Its Results

One obvious feature in the treatment of frostbite in this group of cases by the American military surgeons is the high amputation rate, and a majority of the amputations was done at an unnecessarily high level. Apparently they made very little effort to adopt conservative or restorative type of therapy such as means to improve the regional circulation or plastic methods of wound repair.

ILLUSTRATIVE CASE 10: RECORD NO. 656, CHAO CHING-LUNG (ALIAS SHAN CHEN-LI), I.S.N. 702970. Received a perforating bullet wound of the shoulder in February, 1951. Was captured seven days after being wounded, and in the meanwhile both feet became frostbitten. Two weeks later when only the toes of the left foot were black and dry and while those of the right foot still remained red and the dorsum of this foot was merely swollen, amputation was done at the level of lower thirds of both legs. The wounds were sutured and healed within ten days.

ILLUSTRATIVE CASE 11: RECORD NO. 138, LI CH'IN, I.S.N. 706317. Multiple shell wounds of chest, forehead and right heel in January, 1951. Was captured two days later and sent to Pusan Base Hospital. Within forty eight hours after arrival at Pusan when only the toes of the left foot had turned black and the plantar surface of the foot was merely blistered and macerated, amputation was done through the middle third of the left leg. The wound was sutured and healed within one week.

Comment: In case 10, at the time of operation there was no sign of serious infection. The right foot was free from gangrene and the left foot had only gangrene of the toes. It is quite evident that operation should have been limited to removal of the gangrenous toes of the left foot only; but high amputations were done by the American military surgeons, sacrificing both feet.

In case 11, amputation was done much too soon. The American military surgeons did not even wait for demarcation to occur before they resorted to amputation.

High amputations for frostbite such as described in the above two cases were frequently performed. The wounds were mostly sutured and although they some times healed per primum but often they were reinfected. Consequently reamputations were often necessary and more bone was sacrificed at each subsequent operation.

The types of treatment of the 133 cases and their results are tabulated in Table 2:

TABLE 2. TREATMENT AND RESULT OF 133 CASES OF FROSTBITE OF EXTREMITIES

	With disability		*Healing without disability*	*Total*
	Amputation	*Local resection*		
Number of cases*	93	26	14	133
Percentage	70.0	19.5	10.5	100.0

* Only chief disabling factors are counted in the computation of this table, e.g., frostbite of two limbs with amputation in one and local resection in the other counted as amputation, local resection and healing without disability counted as local resection.

Amputations at varying levels above the site of gangrene were done in 93 cases or 70 per cent, and local resection of gangrenous parts of the limbs in 26 cases or 19.5 per cent. The number of healing without disability was obtained in only 14 cases or 10.5 per cent.

Conservatism has long been recognized as the basic principle in the treatment of frostbite; one should wait for separation of dead tissue and excise only the dead part. The practice of amputation any where above the level of gangrene is rarely if ever necessary.

The American army medical service on the Korean front evidently treated their own frostbite cases in accordance with this well-known principle. In an article as released from the Surgical Consultants Division, Office of the Surgeon General, Department of the Army, Washington, D.C., by Colonel Bowers, W.F., et al., published in the November, 1951 issue of *Surgery, Gynecology* and *Obstetrics,* under the topic of "The Present Story on Battle Casualties from Korea" a definitive statement in regard to the treatment of frostbite was made as the following: "We have advocated ultraconservatism in the surgical sacrifice of tissues subjected to cold injury." Statistics published in the same article showed that total number of amputations (including major and minor amputations, performed overseas and in the United States of America) was only 87 out of 630 cases of cold injuries, constituting an amputation rate of 13.8 per cent. On the other hand, when they treated Chinese prisoners of war with frostbite, in the same period from the same front, they produced the appallingly high amputation rate of 70 per cent. This fact clearly indicates that they had ignored both the principles of medical science and humanitarianism in the management of these cases.

An analysis of the amputation level of frostbite limbs also reveals the fact that the choice of amputation level was seriously against the basic principle of conservatism in the treatment of frostbite. To exclude factors other than frostbite that may appear to influence the choice of amputation level, limbs of frostbite complicated with war wounds are not included in this analysis,

TABLE 3. TREATMENT AND RESULT OF FROSTBITE OF UPPER AND LOWER EXTREMITIES

	Lower extremity				Upper extremity				Total number of limbs
	With disability		Healing without disability	Total	With disability		Healing without disability	Total	
	Amputation	Local resection			Amputation	Local resection			
Simple frostbite	139	49	30	218	14	11	19	44	262
Frostbite complicated by war wound in the same limb	10	1	0	11	2	1	0	3	14
Total limbs	149	50	30	229	16	12	19	47	276

leaving thereby a total of 139 lower limbs that were amputated for simple frostbite (Table 3).

In order to designate clearly the level of the frostbite lesion and that of amputation for the corresponding lesion and show the difference between these levels we have for anatomical and functional reasons divided the lower extremity into nine segments as depicted in the diagram (Fig. 19).

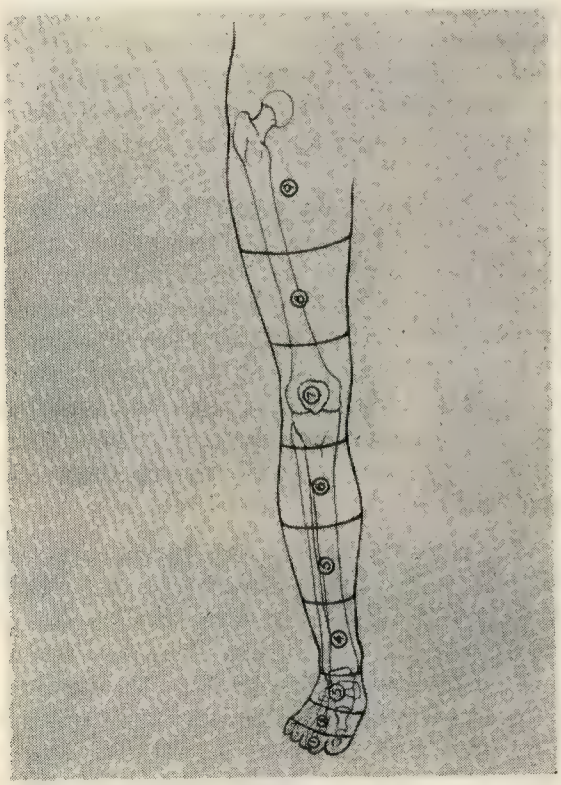


Fig. 19. Arbitrary division of the lower extremity into nine segments.

Table 4 and Figure 20 reveal the startling fact that 84.9 per cent of amputations of lower limbs for simple frostbite were done one or more segments higher than the level of gangrene and in one case it was even five segments higher.

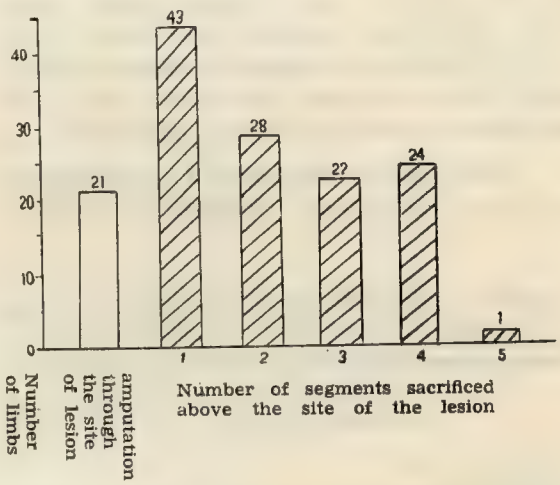
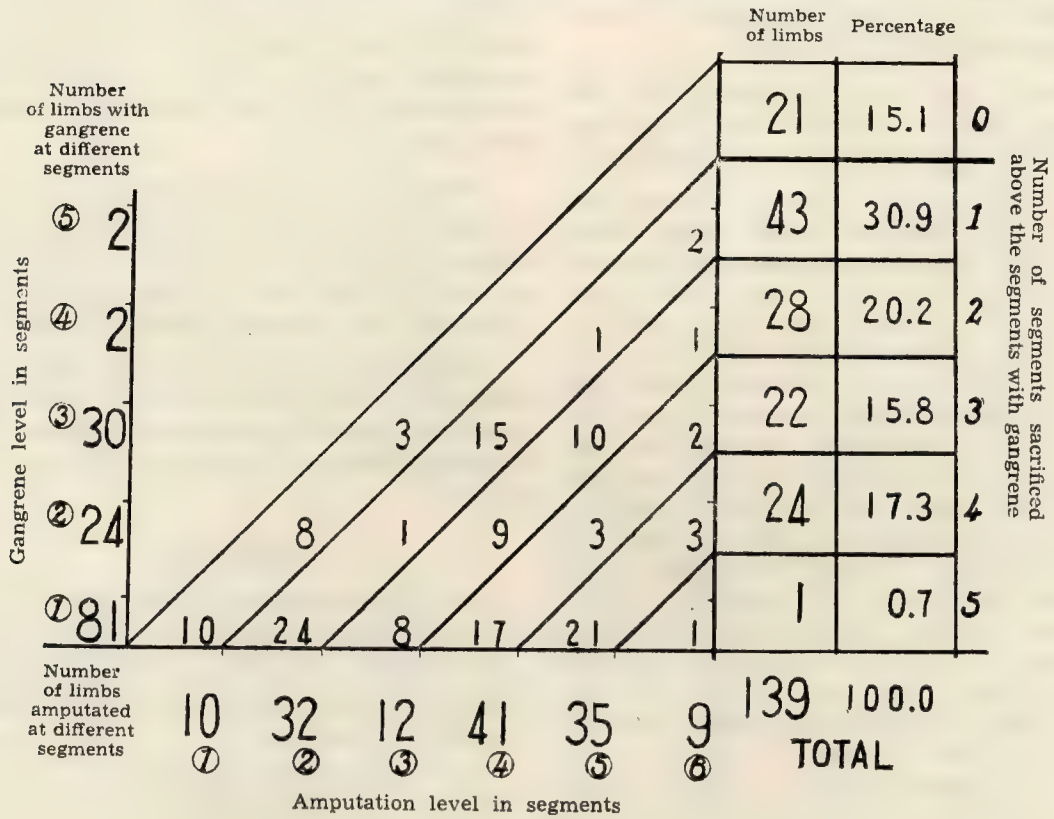


Fig. 20. Relationship between gangrene level and ampulation level in 139 lower limbs with frostbite.

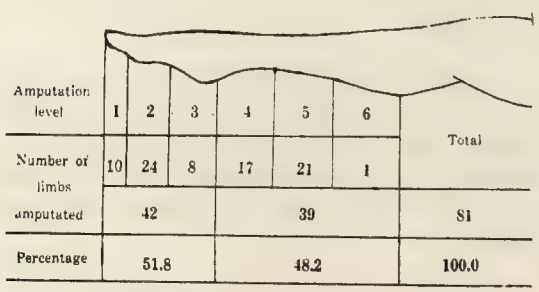
If we take only those cases in which frostbite was distinctly limited to the toes that had become dry and dead, the facts would show beyond a doubt how that American military surgeons sacrificed many useful legs by unreasonable amputations. Figure 21 shows that among a total of 81 legs with only gangrenous toes, amputations through the legs were done in 39, or 48.2 per cent.

Amputations through the toes or even through the metatarsals in these cases

TABLE 4. RELATIONSHIP BETWEEN GANGRENE LEVEL AND AMPUTATION LEVEL IN 139 LOWER LIMBS WITH FROSTBITE



would have cost the patient only certain fine movements of the foot while the main function of the lower limb could still be preserved without artificial means. However, amputations through the legs as were done by the American surgeons in the above cases have left these men permanent cripples.



Amputation level	1	2	3	4	5	6	Total
Number of limbs	10	24	8	17	21	1	
amputated	42			39			81
Percentage	51.8			48.2			100.0

Fig. 21. Distribution of amputation level of 81 lower limbs with frostbite gangrene involving only toes.

These illustrative cases and statistical figures amply prove that the malpractice in the treatment of frostbite by American military surgeons are responsible for the large number of cripples among our returnees.

2. Frostbite that developed in the camp and hospital

Frostbite of the extremities on the battle-ground is perhaps unavoidable; and war prisoners especially the wounded may develop frostbite or have their frostbite aggravated during transportation. These are due to exigencies of war. However it is inexcusable that prisoners of war should develop frostbite in the American camps and particularly in the American base hospitals where the wounded are supposed to be under medical care. Therefore, the American

armed forces must be held responsible for fostbite cases that occurred among our wounded in the American camp and American Base Hospital at Pusan.

Among the 133 returnees that had frostbite 10 were found to have developed frostbite during their period of captivity.

ILLUSTRATIVE CASE 12: RECORD No. 237, TS'AI CHUN-PU, I.S.N. 703288. Shell wound of the left shoulder and traumatic amputation of the left foot ir February, 1951. Three days after his arrival at Pusan Base Hospital his left leg was reamputated through its lower third. The right foot had always been free from frostbite. One cold night, however, his tent, not being firmly tied, was blown over and his bed which was close to the edge of the tent was completely exposed. His right foot consequently became frostbitten. After about thirty days of hospitalization when only the toes of the right foot had turned black and while the dorsum of the foot was merely swollen, the whole foot was sacrificed by amputation through the lower third of the right leg.

ILLUSTRATIVE CASE 13: RECORD No. 773, FANG P'EI-TE, I.S.N. 734581. In the winter of 1951, being a prisoner of war in the American camp on Koji island, he was forced to work in the open without enough clothing to keep warm. He was even forced to walk on the snow-covered ground bare footed. Consequently the toes of the right foot were frostbitten. No treatment was prescribed. Infection then supervened and extended. The thigh was swollen. When he was transferred to Pusan Base Hospital, a lumbar sympathectomy* was done. The condition of the leg gradually improved but the wound of the toes did not heal until February 1952.

Comment: From case 12, one clearly sees that in American base hospitals proper care of the wounded, especially the serious cases, is lacking, even to the extent of permitting their patients to be exposed and to develop frostbite under their very eyes. Incidentally one may point out that the amputation in this case was done at a higher level than necessary.

From case 13, one sees another instance of maltreatment in the American P.O.W. camp. Most of the prisoners were forced to work in the open without proper footwear and were allowed to be frostbitten.

Facts as disclosed in the above cases explain why there have been such widespread protests among the returnees against the inhuman treatment by the American armed forces.

Recapitulation

1. The high amputation rate of 70 per cent of frostbite cases indicates that American military surgeons worked against general surgical principles in the management of these cases.

2. Amputation through the leg in 39 out of 81 feet with frostbite in which the gangrene was limited only to the toes was a criminal procedure that helped increase the high percentage of cripples among the returnees.

3. The fact that the amputation rate for frostbite was only 13.8 per cent for the American armed forces in Korea in exactly the same circumstances indicates that American military surgeons in carrying out their medical duties discriminated against our P.O.W.s.

4. That frostbite had developed not only in the American P.O.W. camp but also in the P.O.W. base hospitals, is one of innumerable facts which reveal the American militarists' inhumane treatment of our P.O.W.s.

* This is the only sympathectomy performed in the whole group of frostbite.

CHAPTER IV

AMPUTATIONS

The review of war wounds and frostbite treated by the U.S. military surgeons thus far has revealed a conspicious phenomenon, viz: negligence of the accepted principles of war surgery and readiness in resorting to amputation as a means of treating wounds of the extremities. This phenomenon, it must be pointed out, is widespread and not incidental. From the medical point of view, amputation as the staple method of treatment for war wounds is primitive and unscientific. From the humanitarian point of view, reckless amputation of extremities is a reflection of cruelty and indifference to humanity. Numerous instances of unnecessary suffering and unnecessary loss of limbs were caused by those U.S. military surgeons, who probably for the sake of simplicity and ease of management cut away retrievable limbs. The real reason is best known to themselves, but we regard this practice as inhumane and unethical. Abuse of amputation therefore warrants further examination.

Among the 1,172 wounded returnees, there are 261 amputees with a total loss of 360 limbs, all following surgery; in other words, many have lost more than one limb. The number alone is appalling. After careful investigation and analysis of these cases and leaving aside those whose histories do not furnish us sufficient evidence for critical allocation of responsibility, we are still left with 98 cases (114 limbs) for whose crippling the U.S. military surgeons should be held responsible. The mistakes in amputation can be broadly classified under the following three headings:

1. Avoidable amputations
2. Amputations at unnecessarily high levels
3. Criminal amputations

1. Avoidable Amputations

Among the 114 erroneous amputations, at least 91 of them could have been altogether avoided. Under this category are included wounds with neither evidence of major vascular injury nor clostridial infection. No effort was made to save the limb. Amputation was employed as primary treatment.

Fig. 22. Case 14. Perforating gunshot wound of the right leg in the middle. Amputation through lower third of the thigh was performed twenty-four hours after the injury was sustained. Reamputated twice because of lack of skin traction.

ILLUSTRATIVE CASE 14: RECORD NO. 489, WANG YUNG-CH'I, I.S.N. 730300. Sustained gunshot wound with compound fracture of the right leg in the lower third on May 26, 1951, at 1:00 a.m. Wound of entrance measured 2 cm., that of exit, 4 cm. First aid treatment was given by our medical worker. At 6:00 a.m. he was captured. On that very day at 6:00 p.m., i.e. within 24 hours of injury, amputation through lower third of the thigh was performed at an American forward hospital. While the limb was being prepared for operation, the victim clearly saw that the wound showed nothing unusual, there was no pus, the color and sensation of the foot on the involved side were normal. He was not feverish.

Comment: In this case, above-knee amputation was performed twelve hours after capture for compound fracture in the lower third of the leg. This practice is definitely at variance with accepted principles of war surgery. Judging from the nature and the duration of the wound, the proper initial treatment would be early debridement and plaster-of-Paris immobilization. But the American military surgeon performed amputation at a high level without any definite indication.

ILLUSTRATIVE CASE 15: RECORD NO. 104, NIU FU-YU, I.S.N. 712550. Sustained perforating gunshot wound in the middle of the right thigh with compound fracture of the femur in May, 1951. Wound of entrance measured 2 cm., that of exit, 4 cm. Seven days later, he was captured. On arriving at Pusan American Base Hospital, an operation was performed followed by immobilization in a plaster-of-Paris hip spica. The wound soon became infected and heavily infested with maggots. On several occasions the patient gathered maggots and showed them to the American military doctor, trying to induce the

A

B

Figs. 23A and 23B. Case 15. Perforating gunshot wound with compound fracture of the middle of the right femur, treated by plaster-of-Paris hip spica for four months. Severe suppuration and maggot infestation under the cast was not attended to. Amputation through the upper third of the thigh was performed simply because of co-existing superficial infection. Roentgenogram to show extreme shortness of the stump.

latter to inspect the wound. But the doctor paid no heed. Four months later when the plaster was removed, the skin was found to have been widely macerated and there were numerous ulcers on the heel and sole of the foot. The toes hitherto uncovered by plaster still remained normal in color and movement. After some twenty days of dressing care, amputation through the upper third of the thigh was performed. Reamputation was performed one month later. All what is left of the stump is just part of the greater trochanter.

Comment: When proper medical facilities are lacking, the appearence of maggots in a wound is no surprise to anybody. But to allow maggots to thrive and multiply under a plaster cast for four months in a base hospital is positive evidence of neglect in the care of infected wounds. In this case, amputation was used apparently to terminate a co-existing superficial infection which could have been controlled very well by conservative means. Amputation in this case was evidently unjustified.

Before passing to the next heading, let us see what American military surgeons say about indications for amputation. The following statements are quoted from an article entitled "Care of Battle Casualties and Injuries Involving Bones and Joints" written by M. Cleveland, J. G. Manning and W. J. Stewart and published in the April 1951 number of the *Journal of Bone and Joint Surgery*, 33-A No. 2:

".....Section A, therapy in division installation...

* * *

V. Amputations

Amputations should not be attempted in the forward treatment stations unless the extremity is almost completely detached.....

Section B, therapy in army installations...

* * *

V. Amputations

1. Indications for amputation

a. Complete destruction of the blood supply. This means the loss of the main artery and most of the collateral arteries.

b. Diffuse clostridial myositis ....."

Apparently the U.S. military surgeons had entirely violated these principles in the treatment of the wounded prisoners of war.

2. Amputations at Unnecessarily High Levels

To say that the U.S. military surgeons did too many amputations for war wounds and frostbite is not presenting the whole truth. It would be more correct to say they did too many amputations at too high levels, thereby sacrificing many serviceable joints and the useful lengths of many stumps. This practice of high amputation is also conspicous. In order to bring out this point, we arbitrarily divide each extremity into nine segments (Figs. 24 and 25). The initial amputations are then classified and graphically represented according to the number of segments that were sacrificed

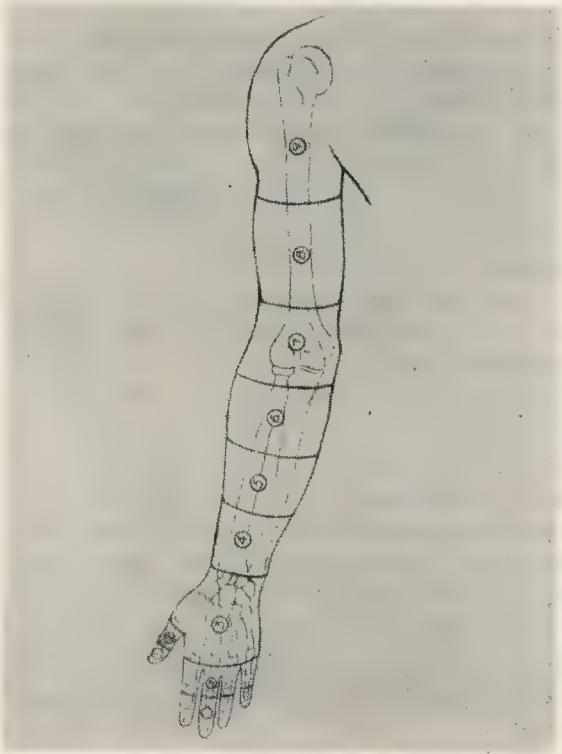


Fig. 24. Arbitrary division of the upper extremity into nine segments.

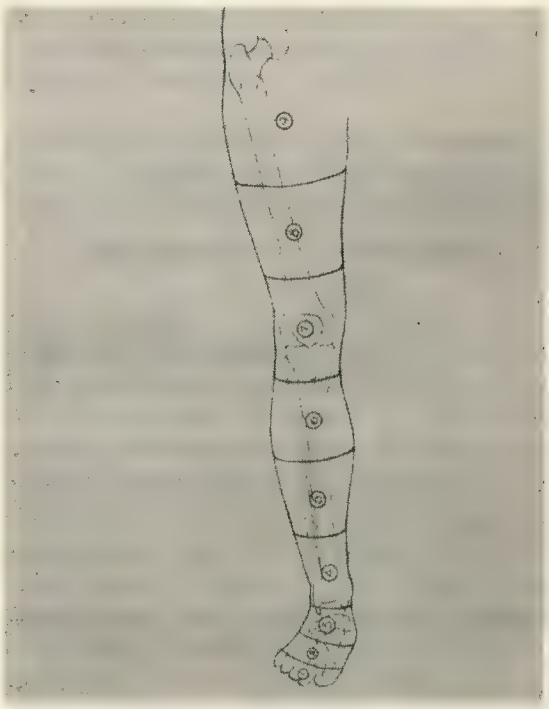


Fig. 25. Arbitrary division of the lower extremity into nine segments.

above the level of the initial wounds. For this purpose, 59 amputations of the upper extremities and 297 amputations of the lower extremities were used for analysis (one upper and three lower extremities were excluded from the series because amputations were done below the site of injury, presumably for vascular injuries).

To take Fig. 27 as an example, we see that for the lower extremities, only 65 amputations were done at the level of the original wound. The majority of the amputations were done higher up. In over half of the cases, two segments above the level of original wound were sacrificed. One case lost as much as seven segments. Fig. 26 depicts the situation in the upper extremities. This presents an even more grave picture. The seriousness of the loss of a hand as a result of high amputation for a finger injury is too evident to require comment.

Figs. 26 and 27 show the trend of practising high amputations by U.S. military surgeons in treating P.O.W.s wounds. No matter how satisfactorily the resulting stump may function, this practice of high amputation for war wounds and frostbite is in itself a breach of accepted principles. Even after high amputations, we have facts to show that they did not take care of the stumps properly, as a result of which reamputations frequently had to be done later with further losses of limb lengths. In a total of 218 open amputations, only 65 had skin traction, adequate or not.

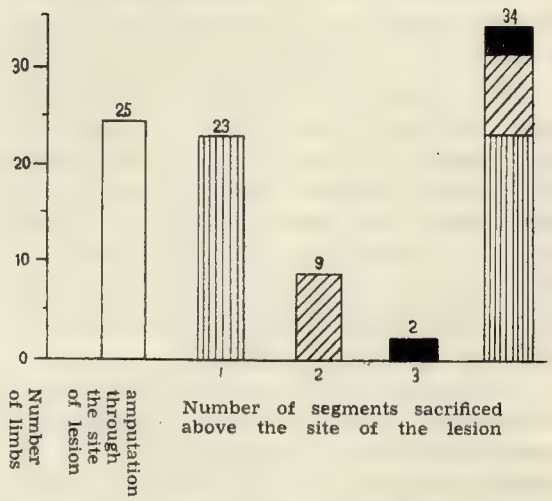


Fig. 26. Relationship between the site of the wound and the level of the primary amputation—upper extremities.

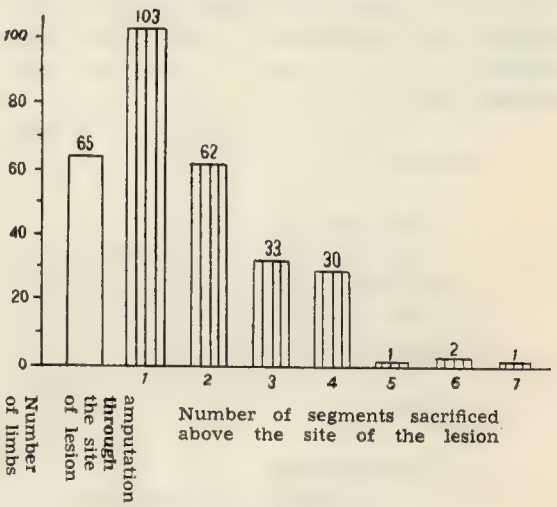


Fig. 27. Relationship between the site of the wound and the level of the primary amputation—lower extremities.

A

B

Figs. 28A and 28B. Case 16. Gunshot wound of the anterior part of the right foot. Was able to go about on heels after injury. Pre-operative preparation was confined to the mid-leg. Amputation was performed through the upper third of the thigh. Wound left open without skin traction necessitating reamputation. Roentgenogram shows the shortness of the stump.

We shall present just three cases to illustrate the malpractice of high amputation.

ILLUSTRATIVE CASE 16: RECORD NO. 261, WANG CH'ANG-HAI, I.S.N. 780298. Sustained machine-gun wound in the right foot on May 24, 1951. For two weeks after his capture, nothing was done to the wound and nobody ever looked after him. The first treatment consisted of amputation through the upper third of the thigh. At the time of amputation, the anterior part of the right foot was swollen and black, but two of the toes were still movable, and the victim had been able to move himself around on his heels with some support. Pre-operative preparation of the skin was confined to the leg, but amputation was performed through the upper thigh. The stump was left open. No skin traction was applied. The bony end eventually stuck out and reamputation had to be done two months later. At present, the stump measured only 3 cm from the tip of the greater trochanter.

Comment: Neglect of the wound for two weeks is already a gross error. Injury was confined to the anterior part of the foot, and the patient was able to move around on his heels; the ankle and the leg had no signs of infection. In spite of all this, the extremity was amputated at so high a level as the upper thigh. To make matters worse, no traction of the stump was applied, necessitating reamputation with further suffering to the victim and loss of bony length. We cannot help but ask what reasons the U.S. military surgeons had in carrying out this kind of treatment.

ILLUSTRATIVE CASE 17: RECORD NO. 675, HU HSIANG-YIN, I.S.N. 700327. Frostbite involving all extremities. Captured in December, 1950. About twenty days after arriving at Pusan American Base Hospital,

Fig. 29. Case 17. Frostbite of all extremities. Right hand: amputated because of frostbite and gangrene of two fingers. Left hand: frostbite of same degree with infection, but the rest of the hand was saved because patient refused amputation. Both legs: amputated in the middle just because of gangrene of toes and redness and edema on the dorsum of the feet.

both legs were amputated through the middle third and the right hand was amputated above the wrist. All the stumps were closed and the wounds healed one week later. At the time of amputation, only the toes were gangrenous. The dorsum of the feet showed only some redness and swelling, there being no ulceration and no blisters. He was still able to bear weight on the heels. As for the right hand, the thumb and the small finger were gangrenous. The other fingers showed dry gangrene up to the middle of the proximal phalanges.

Now, for the left hand, the frostbite was just as bad and besides gangrene there was also some infection. Fortunately, patient persistently refused amputation and so only a local excision of the necrotic parts was done. The wound eventually healed in March, 1951.

Comment: Frostbite injury was confined to the fingers and toes. The gangrene was of the dry type. Evidently, the only correct treatment would be excision of the necrotic parts. But the American military surgeons cut off three of the four limbs in disregard of the principle of ultra-conservatism as advocated by themselves.

ILLUSTRATIVE CASE 18: RECORD NO. 55, YANG TUNG-LI (ALIAS, HUANG HSUEH-LIANG), I.S.N. 730759. Sustained shell wound in the soft tissue of the right leg and ankle. There was no bony injury and the patient was still able to walk following injury. Four to five days later, the toes of the right foot sustained another injury from aerial bombing. This time, foot bones were involved and the wound

Fig. 30. Case 18. Shell wound of the right thigh and ankle, involving soft tissue only. Patient was still able to walk after injury. Few days later the right foot was again wounded by shell fragment. After he was taken prisoner, mid-thigh amputation was performed immediately.

measured 5 cm x 4 cm. Ten days after the last injury, he was captured and removed to Pusan where amputation through the middle of the right thigh was immediately performed. The stump was closed and the wound healed in a week.

Comment: It is evident that the right foot might have been saved and that the right knee joint certainly could have been saved.

Thus far, we have shown the trend of high amputations in general by the U.S. military surgeons. More specifically, there were at least 21 limbs in which amputations seemed justified but were performed at too high levels. As to the 91 limbs already alluded to in the previous section, 74 of them were amputated above the site of injuries. But as these amputations were entirely avoidable, we need not judge them further by the level of the amputation.

Before leaving this subject, let us quote again what American military surgeons themselves say concerning level of amputation *(loc. cit.)*:

"Section B. Therapy in Army Installations.

* * *

V. Amputations...

2. Level of amputation: Amputation should be performed at the lowest possible level which the nature and situation of wound will permit.

3. Type of amputation: Experience has shown that the open circular amputation is the procedure of choice in the treatment of war wounds.

4. Technique of open circular amputations...

* * *

k. Skin traction should be applied immediately and be maintained continuously while the patient is being evacuated and until healing takes place..."

3. Criminal Amputations

In this category, amputation was utterly groundless and the procedure seemed to be done for some purpose other than medical.

ILLUSTRATIVE CASE 19: RECORD NO. 52, CHANG HUA-SHENG, I.S.N. 730242. Sustained perforating gunshot wound in the right leg and lower third of the right thigh. Only soft tissue was involved. He dressed the wound himself and continued to proceed on foot for three days, traversing a distance of about 50 kilometers over a hill. He was then captured and sent to a forward hospital. En route, he got on and off the lorries unassisted. After arriving at an American forward hospital, he was given an injection and a pill, after which he fell asleep. On awakening, he found his right thigh already amputated through the lower third.

Fig. 31. Case 19. Perforating gunshot wound of the right thigh and leg involving soft tissue only. After injury, he continued to walk for three days and climbed a hill. After being captured, amputation through mid-thigh was immediately perperformed.

Comment: It is certain that the patient had no bony injury, no vascular or nerve injury and no serious wound infection, for otherwise he could not have walked 50 kilometers and climbed over a hill. The amputation therefore was utterly groundless. We regard this kind of treatment criminal.

ILLUSTRATIVE CASE 20: RECORD No. 182, LIANG CHIN-HUAI, I.S.N. 719717. Sustained light machine gun wound in the left index and middle fingers at the proximal phalanges on September 25, 1952, at 5 a.m. The said fingers were almost detached. He was captured at 2 p.m. and moved to an American hospital at 8 p.m. The next day at 2 p.m., i.e., 33 hours after the injury, he was sent to the operating theater without any preparation and a forearm amputation was done. At the time of surgery, the palm was normal in color showing only slight swelling. The thumb, ring finger and the little finger were free from involvement.

Fig. 32. Case 20. Gunshot wound of the index and middle fingers of the right hand. Amputation through the middle of the forearm was performed by the American military surgeons 33 hours after capture.

Comment: Injury of the index and middle fingers with other fingers intact. Initial surgery should be limited to excision of the injured members. But the American military surgeons ignored the intact fingers and amputated the hand above the wrist. For the upper extremity, this is more than a high amputation. It is criminal mutilation.

Recapitulation

1. The U.S. military surgeons, in handling war wounds and frostbite, employed amputation as the essential measure of treatment.

2. The vicious practice of the U.S. military surgeons is responsible for the loss of 114 limbs.

3. Most of the amputations were performed high with unnecessary loss of joints and limb lengths.

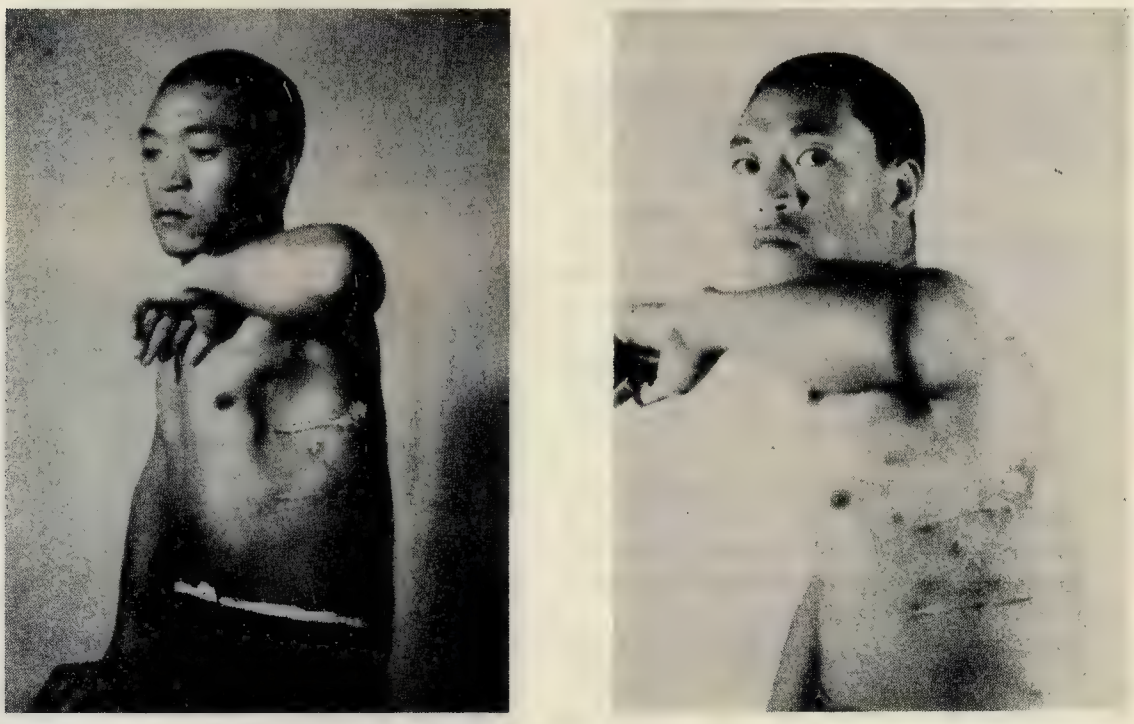
4. Amputations were even performed on grounds other than medical.

CHAPTER V

OTHER WAR WOUNDS

Aside from the numerous errors committed by the American military surgeons in the treatment of bone and joint injuries, and frostbite, described in the previous chapters, serious mistakes in the management of other types of war wounds are also evident. Some of the illustrative cases are presented below:

ILLUSTRATIVE CASE 21: RECORD NO. 1499, SUN PAI, I.S.N. 731554. Sustained a gunshot wound of the left chest, in the middle of October, 1951. Early on the morning after he was wounded, he was captured and transported to Pusan Base Hospital where he was operated upon for the first time. After the operation he continued to have fever, coughing of blood and leakage of air through the wound. Two months later, a second operation was performed and a rubber tube was inserted into the chest wound for drainage, with no relief of symptoms. After three more months, a third operation, presumably a Schede's thoracoplasty, was carried out. Three weeks later, coughing of blood stopped but leakage of air through the wound continued for a considerable length of time.



A B

Figs. 33A and 33B. Case 21. Gunshot wound of the left side of chest. Due to erroneous treatment, patient continuously suffered from respiratory difficulty. Fig. 33A and 33B illustrate the condition of chest wall during inspiration and expiration.

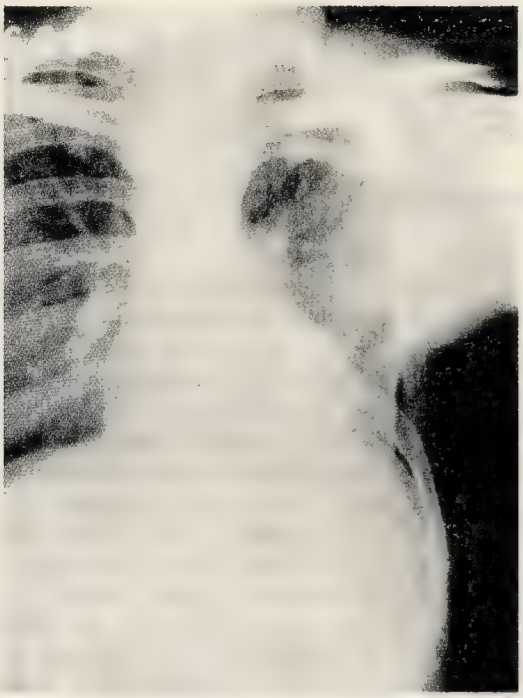


Fig. 33C. Case 21. Shows complete surgical absence of the sixth and seventh ribs and part of the fifth rib. The pleura is only slightly thickened.

In June, 1952, eight months after hospitalization, two shell fragments were extracted from the wound during dressing. In another two months the wound healed.

Today, nearly one year after the healing of the wound, the left anterolateral chest wall still appears as a big hollow depression and flutters continuously during respiration. Respiratory rate is 30 per minute during rest but becomes very much accelerated following only a slight exertion, and patient appears very much dyspneic.

Roentgenogram shows complete absence of the sixth and seventh ribs and partial absence of the fifth rib of the left side of the chest. Thickening of pleura is minimal.

Comment: In the management of the above case, the American military surgeons had committed errors in the following aspects:

a. The first two operations were not properly performed. Had the shell fragments been removed earlier and adequate drainage of the pleural cavity been established following the operation, the chronic empyema in this case could have been prevented.

b. The extensive thoracoplasty that was done at the time when the pleura was not sufficiently thickened was contrary to accepted principles.

c. In spite of the patient's respiratory difficulty after the thoracoplasty, the American military surgeons took no measure whatsoever, not even the simple application of a pressure pad over the chest wall to control the paradoxical respiration.

ILLUSTRATIVE CASE 22: RECORD NO. 518, WANG CH'UAN, I.S.N. 706386. Compound fracture of the upper third of the right leg and penetrating wound of the right thigh following shell explosion and frostbite of toes of both feet in February, 1951. Five days after injury, he was captured and sent to Pusan Base Hospital. For the condition of the right leg he was operated upon 15 times, 11 of which at intervals of 2-3 weeks. At the 14th operation the common peroneal nerve was in-

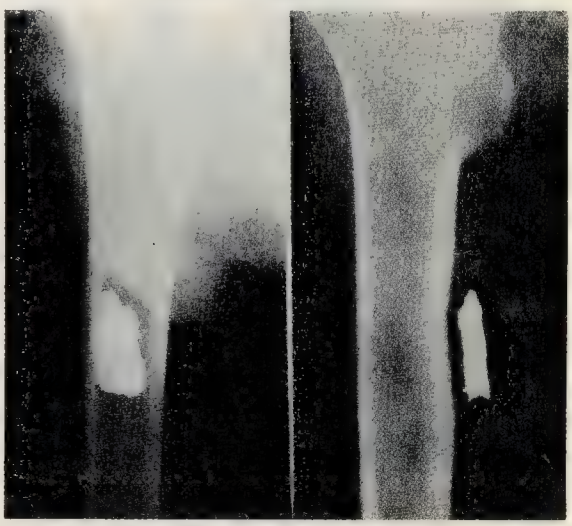


Fig. 34A. Case 22. Shows retention of shell fragment in right thigh.

B

C

Figs. 34B and 34C. Case 22. Compound fracture of the upper third of right leg following shell wound, and frostbite of toes of both feet in February, 1951. Captured 4-5 days after injury. Deformity of right foot resulted from surgical severence of common peroneal nerve.

advertently severed, resulting in a permanent foot drop. The wound in the upper third of right thigh was left without any treatment.

Present examination reveals absence of the toes and metatarsal heads of right foot that resulted from operation for frostbite. What is left of the foot is in equino-varus deformity. Active dorsiflexion of ankle and eversion of the foot are lost. Upper third of the right thigh has a discharging sinus in its medial aspect. The roentgenogram shows a big shell fragment quite near the site of the discharging sinus about 8 cm below the lesser trochanter.

Comment: The severence of common peroneal nerve causing crippling in this patient is directly attributed to surgical negligence on the part of the American military surgeons. The unusual frequency of operation at short intervals on the leg clearly indicates that most of them must have been improperly indicated, and poorly done, causing unnecessary suffering to the patient. On the contrary, although there was clear indication for the removal of the shell fragment which was preventing the discharging sinus from healing, yet the American military surgeons allowed it to remain for more than two years.

ILLUSTRATIVE CASE 23: RECORD NO. 1314, WANG HSIEN-T'ING (ALIAS, WANG SHENG-HSUNG), I.S.N. 707633. Captured on May 27, 1951, without any previous combat injury. On October 1, 1952, during the prisoners' celebration of the Third Anniversary of the People's Republic of China, he was shot by the American soldiers in several places, all the wounds being in the soft tissues. The wounds were debrided one and a half days later, followed by a secondary closure after four days. Some of the wounds healed seven days after the suture, while others suppurated. The one which was situated

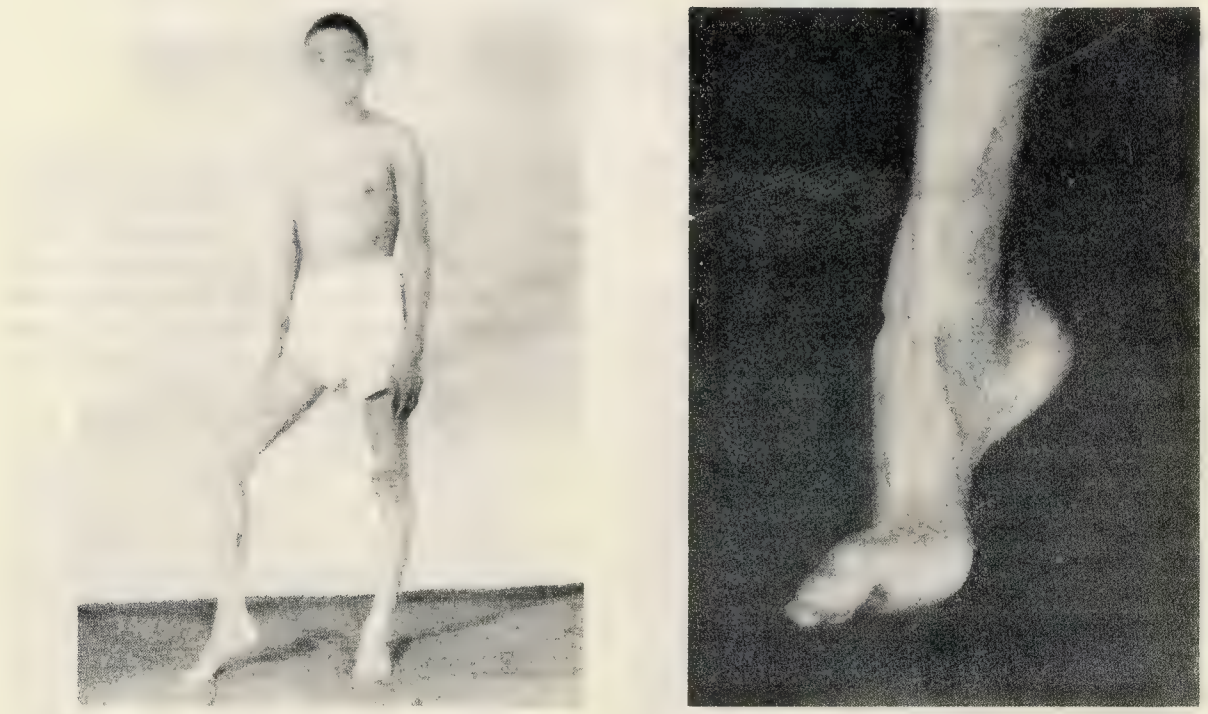
in the middle part of the back of the right leg was quite deep and did not heal until three months afterwards. During all this period neither was splintage applied to the leg, nor were functional exercises prescribed for the patient.

Examination at present reveals marked fixed equino-varus deformity of the right foot due to severe contracture of the tendo-achillis. The peroneal muscles and the tibialis anticus muscle are overstretched but not paralyzed.

Comment: The deformity of foot in this case is a direct result of the contracture of tendo-achillis. It could have been prevented had the American military surgeon taken even such a simple measure as proper splintage of the foot.

ILLUSTRATIVE CASE 24: RECORD NO. 1413, K'ANG MING-CH'UAN (ALIAS, WANG HSIAO-TI), I.S.N. 780387. He was medically examined when he was in China and the vision of both his eyes was normal.

During the fighting at the central front on the south bank of the Han River on October 2, 1951, his left eye was hit by small particles of rock following an explosion of a shell. He managed to bandage his injured eye. About two hours later, he was captured by Rhee's regiments where he was questioned till late at night. During the questioning he was twice beaten with a wooden club. On the next day he was sent to one of the American divisional headquarters where he was again questioned for several hours. He was then sent to Seoul after about four days. During these days he received no food, and his bandaged eye was never opened for examination. He stayed in Seoul for over half a month but his eye dressing was changed only twice. From Seoul he was removed to Pusan. Here his wounded eye was examined for the first



A B

Fig. 35. Case 23. Wounded by American soldiers in several places during the celebration of the Third Anniversary of the People's Republic of China on October 1, 1952. During treatment no measure was taken to prevent contracture of tendo-achillis. Figs. 35A and 35B show the patient and the marked contracture of tendoachillis of the right leg.

time and it was found that its vision was impaired. After two months the local inflammatory symptoms subsided, and gradually he could count fingers at about one foot.

In June, 1952, he was sent to Cheju Island. During his stay there, there were four attacks on prisoners with poisonous gas, and in about a month the vision of his left eye was completely lost. Henceforth, this eye still frequently showed symptoms of irritation.

On examination in September, 1953, after his repatriation, his right eye was found normal. The left eye showed adherent leucoma and atrophy of the eyeball with some pericorneal injection present.

Comment: The history of this case shows that after he was wounded and captured for several days he was given no food. He was repeatedly questioned for military information and was twice beaten with a wooden club. At the regimental and divisional headquarters, where medical officers and medical facilities should have been available, nothing was done to his injured eye. Delay in treatment resulted in the blindness of the left eye. Further, when the injured eye was already blind and atrophic, and irritation still remained, the American medical officers did not take the eye out to protect the sound eye from the danger of sympathetic ophthalmia.

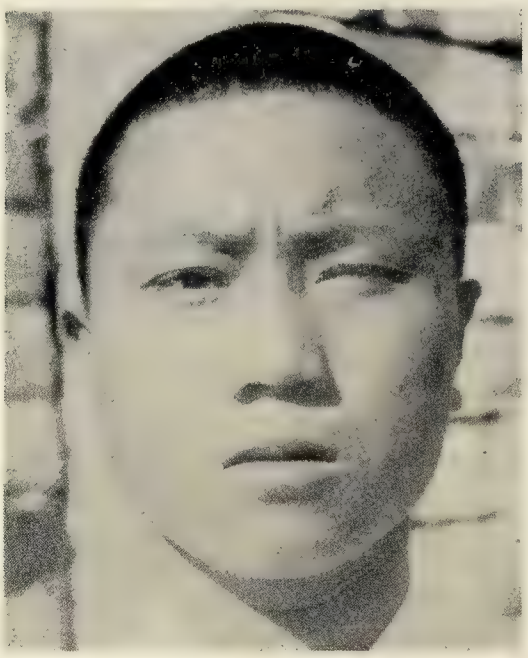


Fig. 36. Case 24. Photo shows atrophy of the left eye resulting from negligence in treatment on the part of American military surgeons.

ILLUSTRATIVE CASE 25: RECORD NO. 1442, HU T'IEN-SHENG (ALIAS, WANG CHIN-YU), I.S.N. 731422. He was medically examined when he was in China and his eyes were found normal.

In the afternoon of October 7, 1951, at the Korean central front he was knocked out by an explosion and was unconscious for several hours. When he regained consciousness, he found that he was a prisoner and that his right eye was very painful and its vision was lost. In the course of the day he was sent to the regimental and divisional headquarters and was questioned for military information. On the 9th of October he was sent to Seoul and on the 12th was taken to Pusan. During these days his eye caused him terrible pain but he was given no medical attention. At Pusan he was given penicillin injection and his eye dressing previously applied by his comrade was changed twice a week. After a month the inflammation of the eye had gradually subsided. But the upper lid was adherent to the socket and the conjunctiva in the palpebral fissure region was exposed, on account of which and the wind and dust that caused irritation he suffered greatly from tearing and sandy sensation.

Examination in September, 1953, after his return to China, showed that the socket of his right eye was shallow, the posterior surface of the right upper lid was adherent to the highly atrophic eyeball, and that the conjunctiva within the palpebral fissure region was entirely exposed with marked injection present.

Comment: At the time of capture, the injury, which was very serious and required attention, was neglected, and in

consequence the eye remained in a most painful state for a number of days. Apparently the American militarists were interested only in military information. Even after his arrival at Pusan, no proper measures were taken to prevent the formation of symblepharon. This neglect led to an ugly deformity of the eye, with the result that the conjunctiva was exposed to the air day and night, and the eye suffered constantly from irritation. This condition of the eye gave the victim not only physical pain but also mental suffering.

Fig. 37. Case 25. Photo shows ugly deformity of the right eye, resulting from negligence on the part of American military surgeons.

The American army medical officers must be held responsible for the ill consequence that befell this wounded soldier on account of their criminal neglect.

Recapitulation

In the previous chapters we have pointed out a number of errors committed by the American military surgeons in the treatment of bone and joint injuries and frostbite. In this chapter more facts are presented to illustrate their negligence and errors in treating various other kinds of war wounds.

As illustrated by the cases cited above, they allowed an injured eye to develop symblepharon without any active treatment; they did not remove, as they should have done, an irritating and functionless eye to prevent sympathetic ophthalmia; they inadvertently cut an important nerve during operation, causing paralysis and deformity; they performed thoracoplasty without proper indication and left the patient with a fluttering chest wall without further care; they even failed to do such a simple thing as applying a proper splintage to prevent contracture of tendo-achillis.

In short, the U.S. military surgeons, owing to their gross negligence and errors, not only failed to relieve the suffering of our men but created serious deformities and disabilities.

CHAPTER VI

NUTRITIONAL CONDITION

Malnutrition of the returnees is quite general. Since with the sick and wounded it is not possible to eliminate disease as it affects nutrition, our investigations were confined to 1,045 returnees who were not classified as sick and wounded. These returnees were a part of those repatriated after the signing of the Armistice Agreement, taken at random and not selected. The results of the investigation show the following evidences of malnutrition:

a. Feeble and haggard appearance and loss of weight.
b. Anemia.
c. Vitamin A deficiency.
d. Riboflavin deficiency.
e. Increase in capillary fragility.

Details of these manifestations are as follows:

1. General Condition

The general condition of these returnees was unhealthy. They appeared thin and were obviously in a weak state with pallid complexion and dry skin. They were dejected and looked older than their age. Almost every one of them felt loss of strength and were easily fatigued, and the least exertion in running or climbing gave them shortness of breath. After their return, although they had eight to nine hours of sleep, it was still insufficient. Their appetite had increased, but they ate much less than before they were interned. In many cases they ate only one half of what they used to before their capture.

2. Body Weight

The 1,045 returnees were all weighed when they first came back and again 26 days after; and, with the exception of cases of nutritional edema in which weight decreased with improvement in diet, a large majority (over 80 per cent) showed definite increase in body weight, as set forth in the following table:

TABLE 5. INCREASE IN BODY WEIGHT

Body weight (Kg)		*No. of returnees*	*Percentage*
Total number of returnees who gained weight		841	80.9
Increase in weight:	9 or over	6	0.6
	8—9	7	0.7
	7—8	14	1.3
	6—7	27	2.6
	5—6	71	6.9
	4—5	98	9.4
	3—4	151	14.4
	2—3	213	20.6
	1—2	208	20.0
	below 1	46	4.4
Total number of returnees who did not gain weight*		199	19.1
TOTAL		1,040‡	100.0

* Of these 199 returnees, 76 showed no increase in weight and 123 lost weight on account of nutritional edema.

‡ The total number of returnees should be 1,045, but the weight of 5 of them are not available.

The gain in weight shown above accounts for only a portion of the weight lost during their imprisonment. We must take into consideration the facts that (a) the returnees' period of recuperation is still short and their weights are still on the increase, and (b) that, owing to hydration of tissue in undernutrition, in the period of rehabilitation preceding the weight gain there is often an initial loss. With these considerations, it is significant that 841 returnees already showed a weight increment, with an average gain of 2.8 kilograms per person, and that among them 125 gained over 5 kilograms in weight. This is strong evidence that our returned personnel had lost considerable weight during their period of imprisonment.

3. Hemoglobin

The hemoglobin concentration of 785 from among this group of non-sick-and-wounded returnees, taken without selection, was determined. As shown in Table 6 the hemoglobin concentration of a great majority of the returnees was below normal. Over 80 per cent was below 12 grams, over 60 per cent below 11 grams, over 40 per cent below 10 grams, with an average of 10.3 grams. These non-sick-and-wounded returnees were classified by the other side as "healthy" and were repatriated after the signing of the truce agreement. They have recently had no hemorrhage, surgical operation or any disease that might cause anemia. That anemia is so widespread cannot be explained on an individual basis. The cause must be found in what affected in common all these returnees, and such a collective cause in the circumstances could only be malnutrition.

TABLE 6. HEMOGLOBIN CONCENTRATION

Hemoglobin gm per 100 cc	*No. of returnees*	*Percentage*
Below 7	18	2.3
7— 8	58	7.4
8— 9	102	13.0
9—10	137	17.5
10—11	186	23.8
11—12	154	19.6
12—13	90	11.4
Above 13	40	5.0
TOTAL	785	100.0

The average hemoglobin concentration was 10.3 grams per 100 cc.

4. Vitamin Deficiencies

These were in the main vitamin A and riboflavin deficiencies. We diagnosed vitamin A deficiency on the basis of night blindness, follicular hyperkeratosis, Bitot's spot or xerophthalmia and diagnosed riboflavin deficiency on the basis of cheilosis, stomatitis, glossitis or scrotal dermatitis. Actually more than one of these manifestations were present in the majorities of the diagnosed cases and only in a small number of instances was the diagnosis based on only one specific sign.

For capillary fragility test we used Wintrobe's method, a positive test means the presence of at least 21 petechiae in an area with a diameter of 5 cm.

The results of these examinations are listed in Table 7.

TABLE 7. VITAMIN DEFICIENCIES*

Vitamin deficiencies	*No. of returnees*	*Percentage*
Vitamin A deficiency: Total	939	89.9
Night blindness	546	52.2
Follicular hyperkeratosis	659	63.1
Other Eye signs	521	49.9
Riboflavin deficiency: Total	833	79.7
Cheilosis	704	67.4
Stomatitis	96	9.2
Glossitis	38	3.6
Skin changes (scrotal dermatitis, etc.)	408	39.0
Capillary fragility—positive reactors‡		17.7

* Total number of returnees examined was 1,045. The number of returnees with both vitamin A deficiency and riboflavin deficiency was 809 and of those with either one of the two deficiencies was 214, making up a total of 1,023, 97.9 per cent of the number of returnees examined.

‡ In the capillary fragility test there were 72 positives out of 407 returnees examined.

From the data given in Table 7 one may see clearly that nutritional deficiencies as observed among the non-sick-and-wounded repatriates are extremely serious. More than half of them showed night blindness and as many as 63.1 per cent, follicular hyperkeratosis. The total number of cases with manifestations of one form or another of vitamin A deficiency came close to 90 per cent. Likewise, riboflavin deficiency is quite general, totalling 79.7 per cent, and if the symptoms and signs during internment were also taken into account, as high as 88 per cent. About 18 per cent gave positive capillary fragility test, indicating that subclinical vitamin C deficiency also exists.

In general, appearance of vitamin deficiencies is determined to a considerable extent by the total caloric intake. With the same degree of vitamin deficiency, what may appear as an overt deficiency disease with

a liberal intake of calories would be inapparent after prolonged starvation. Our repatriates were grossly under-fed, and their caloric intake was very low for a long period. Hence, the incidence of vitamin deficiency disclosed by our examinations could not sufficiently show the seriousness of the malnutrition that prevailed in the American P.O.W. camps.

In summarizing the results of the above examinations, it must be concluded that the nutritional status of the returnees is uniformly bad. Under-nutrition and malnutrition predispose to various acute and chronic diseases. For example, protein deficiency and vitamin C deficiency adversely influence wound healing; avitaminosis A through its effect on the epithelial tissue renders the respiratory tract more susceptible to infection. It is therefore possible to explain partly on nutritional grounds why so many of our returnees are afflicted with serious illnesses.

5. Causes of Malnutrition

In the previous section we have shown beyond doubt that the nutritional status of all the repatriates has been uniformly bad and that the incidence of various deficiency diseases among them is alarmingly high. The usual causes of nutritional deficiency are: 1. Factors inside or outside the human body interfering with the digestion and absorption of food material; 2. Factors inside or outside the human body causing an increased demand for nutrient materials; 3. Insufficiency of food intake in quality and quantity; 4. Combinations of the above factors. Considering the conditions that prevailed in the American P.O.W. camps in South Korea, it is not difficult to understand how such a widespread deficiency status existed among our repatriates. The factors that brought about malnutrition were:

a. Massacre, terrorism and brutal treatment were constantly resorted to in the American P.O.W. camps, and these resulted in adverse metabolic changes and interference with food digestion and absorption. Deprivation of food frequently imposed as a penality of course affected nutrition more directly.

b. Prisoners were constantly subjected to forced labor, and long hours of strenuous physical work undoubtedly increased the demand for nutrient material.

c. The factor affecting nutrition most directly was, of course, the quality and quantity of the food itself. According to the information so far gathered, the food for P.O.W.s in the American camps was insufficient and poor in quality.

Returnees uniformly reported that they had never had a single full meal throughout their stay in the camp. A number of the returnees had worked for some considerable time as mess cooks in their camps. They knew quite accurately the details of the daily rations. From their figures, the average daily amount of food per capita could be computed. Such computation is of course a rough estimate only and may even be higher than the actual consumption, but it suffices to show that the P.O.W.s were living in a state of semi-starvation. The total caloric intake was insufficient. The amount of fat and animal protein was far below requirement. All the vitamins were low, vitamin A in particular amounting to only one-tenth of the required amount. Riboflavin was also very deficient. So was vitamin C. Such a grossly insufficient and ill-balanced diet is in complete agreement with the shockingly bad nutritional status and the high incidence of nutritional deficiencies, found among the repatriates.

The P.O.W.s in South Korea were in a state of semi-starvation. That the American camp authorities have violated Article 26 of the Geneva Conventions of August 12, 1949 which provides that "The basic daily food rations shall be sufficient in quantity, quality and variety to keep prisoners of war in good health and to prevent loss of weight or the development of nutritional deficiencies...." is an undeniable fact.

CHAPTER VII

TUBERCULOSIS

There were 230 cases of tuberculosis among the 567 returnees classified as medical cases. Their conditions were carefully studied with complete histories, physical examination, laboratory tests including sputum examination and erythrocyte sedimentation rate, and roentgenography of the chest. According to the results of these investigations, the lesions and their clinical activities are classified in the following table:

TABLE 8. CLASSIFICATION OF CASES OF TUBERCULOSIS

Type & activity	*First group of sick & wounded returnees*	*Second group of sick & wounded returnees*	*Total*
Tuberculosis	131	99	230
Pulmonary tuberculosis*	101	66	167
Quiescent	21	27	48
Active	80	39	119
Moderately active	44	29	73
Markedly active	36	10	46
Tuberculosis of tracheobronchial lymph nodes	5	1	6
Pleurisy	6	8	14
Thickening of pleura	19	24	43
With thoracentesis in POW camp	8	13	21
Without thoracentesis	11	11	22

* Activity of pulmonary tuberculosis is classified according to the following criteria:

1. Quiescent: (1) Roentgenogram revealing fibrosis or calcification in most of the lesions. (2) Tubercle bacilli not found in the sputum. (3) Normal erythrocyte sedimentation rate. (4) Absence of toxic symptoms.
2. Moderately active: (1) Roentgenogram revealing small amount of infiltration, not quite well fibrosed. (2) Tubercle bacilli may or may not be found in sputum. (3) Erythrocyte sedimentation rate normal or slightly accelerated (below 30 mm at the end of first hour). (4) Toxic symptoms present or absent.
3. Markedly active: (1) Roentgenogram revealing more extensive productive, caseous or exudative lesions, with or without cavitation. (2) At least one of the following 3 features: a) Tubercle bacilli in sputum; b) erythrocyte sedimentation rate more than 30 mm at the end of first hour c) presence of toxic symptoms.

Our study of the 230 cases of tuberculosis brought out the fact that in these cases the initiation of clinical symptoms or their exacerbation was closely related to the extremely obnoxious environment, in which these affected P.O.W.s found themselves, and to the cruel treatment they received from the hands of the camp authorities. Our captured personnel during their internment were subjected to inhumane treatment and all sorts of brutalities, from which sick patients were not exempted. A total of 186 out of the 230 tuberculous patients (see Table 8) were brutally treated before or during their illness, and among these 186, 142 had pulmonary tuberculosis. Still more shocking was the fact that as a result of the revoltingly inhuman treatment in the camps 46 of the patients with pulmonary tuberculosis developed markedly active lung lesions. More details are given below:

1. How Symptoms Began

In the Second World War, the P.O.W. camps of the German and Japanese Fascists were hot-beds of tuberculosis, where nutritional deficiencies and poor living conditions favored the occurrence and spread of this disease. Today we find an American counterpart in the P.O.W. camps in South Korea. It is not strange that among our sick and wounded returnees so many of them should have developed tuberculosis during their internment.

The great majority of the 230 patients with tuberculosis had no manifestation of this disease before their capture, their symptoms developed after their living in the camps. A few of them had occasional

coughs before, but their symptoms got considerably worse after a period of internment.

Evidently, factors that were concerned in these cases in the pathogenesis or exacerbation of the tuberculous infection could not be anything other than what prevailed in the American P.O.W. camps. In many patients, their illnesses were directly attributable to the camp authorities' atrocities—forced labor, beating, torture, poison gas, deprivation of food and water, etc. The following four cases are but a few of the many.

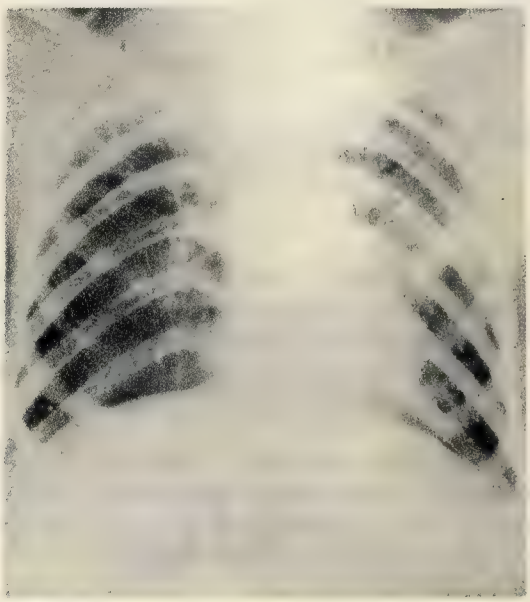


Fig. 38. Case 26. Caseous and exudative lesions in the upper third of the right lung and the upper two-thirds of the left lung. Cavities of different sizes are noted among the caseous lesions.

ILLUSTRATIVE CASE 26: RECORD NO. 933, FENG NIEN (FENG JIH-CH'ENG), I.S.N. UNKNOWN. Male, 21 years of age. Date of capture, May 28, 1951. No respiratory symptom whatsoever prior to capture. After internment received repeated ill-treatment—tattooing, clubbing and other abuses. In September 1952 after 3 successive poison gas attacks, began to have cough and expectoration. The sputum was yellowish, foul and blood stained. Also had chest pain, night sweats, loss of weight and general malaise. During the illness, was attacked by poison gas 5 more times (see Table 9), further aggravating his condition. In December 1952, was examined with x-ray and told to have "pulmonary disease". He was then "hospitalized" at Pusan.

After repatriation, still had chest pain, cough with yellowish, bloody sputum and fever (38° C.). Tubercle bacilli were found in the sputum. Roentgenogram of the chest (Fig. 38) showed caseous and exudative lesions in the upper third of the right lung and upper two-thirds of the left lung. In the caseous lesions there were cavities of various sizes.

This case illustrates that symptoms of pulmonary tuberculosis developed after the P.O.W.s stay of one year and four months in the American camp, in the wake of maltreatment and poison gas attacks.

ILLUSTRATIVE CASE 27: RECORD NO. 820. SHAO CHANG-KEN, I.S.N. 713835. Male, 30 years of age. Date of capture, May 21, 1951. No respiratory symptoms before capture. After capture was constantly in

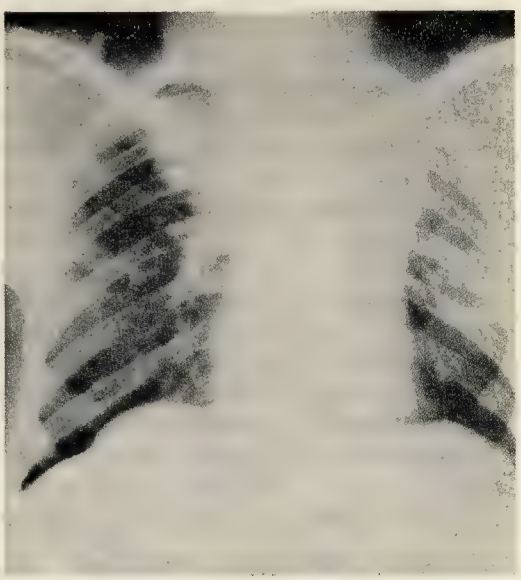


Fig. 39. Case 27. Extensive caseous infiltrations with cavities in the upper two-thirds of both lungs. Pleura of the left chest and mediastinum is thickened.

hunger and insufficiently clothed. In October 1951, while engaged in forced labor in Compound 72, Koje, was badly beaten on his chest and immediately he spat blood and coughed with expectoration. Two days later, symptoms became worse and he was "hospitalized" in Pusan. In January 1952, cough became worse with greenish foul sputum, chest pain and fever. Hemoptysis occurred again in April 1952. Continued to receive brutalities in the course of his illness (see Table 9).

After repatriation, still had cough with sputum, fever and chest pain. Roentgenogram of the chest (Fig. 39) revealed extensive caseous infiltrations in the upper two-thirds of both lungs, with many small cavities. Pleura of the left chest and mediastinum was thickened. The erythrocyte sedimentation rate was 60 mm at the end of first hour. Tubercle bacilli were present in the sputum.

This case illustrates that physical torture was followed by hemoptysis and other symptoms of pulmonary tuberculosis.

ILLUSTRATIVE CASE 28: RECORD NO. 842, WANG HSUEH-HSIN (WANG HSIAO-HSING), I.S.N. 716989. Male, 29 years of age. Date of capture, May 1951. No respiratory symptoms prior to capture. In June 1951, was grilled whether he was a member of the Communist Party and was severely beaten with club to unconsciousness. Was swollen and sore all over. About 20 days later, cough supervened. The sputum was yellowish white with blood streaks. Had hemoptysis in August and December 1951 and in December 1952. Had also shortness of breath, palpitation of heart, chest pain, feverishness, night sweats, general malaise and loss of appetite. Roentgenological examination was made in August 1951. Was told to have "pulmonary disease" and sent to Pusan, where physical torture continued (see Table 9).

After repatriation, still had cough with large amount of sputum and fever. Roentgenogram of the chest (Fig. 40) showed patches of exudative and caseous lesions scattered about both lung fields. Many small cavities were present. The erythrocyte sedimentation rate was 58 mm at the end of the first hour. Tubercle bacilli were found in the sputum.

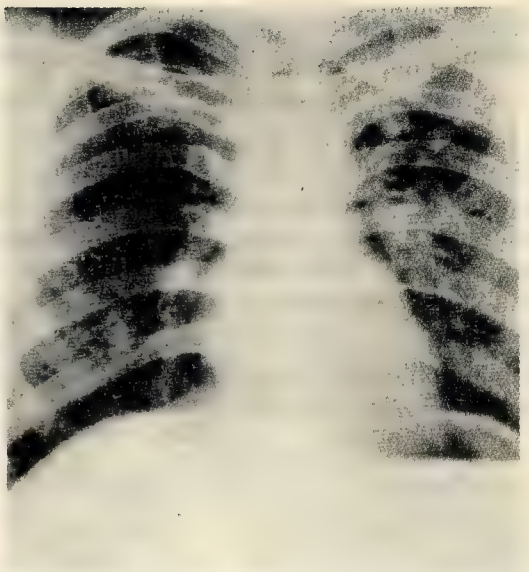


Fig. 40. Case 28. Patches of exudative and caseous lesions scattered all over both lung fields. Small cavities are present in the lesions.

This case illustrates that the P.O.W. developed symptoms of pulmonary tuberculosis in the American P.O.W. camp, twenty days after being ruthlessly beaten.

ILLUSTRATIVE CASE 29: RECORD NO. 935, CH'EN CHI-HOU, I.S.N. 707432. Male, 25 years of age. Date of capture, May 26, 1951. No respiratory symptoms prior to September 1951. In the POW camp was often spitefully beaten and kicked, sometimes to the point of unconsciousness. Frequently had to serve forced labor and sometimes crawl on all fours. In September 1951, in Compound 86, Koje, was ruthlessly beaten. Immediately, he spat blood and began to have severe cough with large amount of foul sputum. The distressing cough persisted and later chest pain and fever developed. Had hemoptysis every 2 or 3 months. Was examined with roentgenography in November 1951 and then

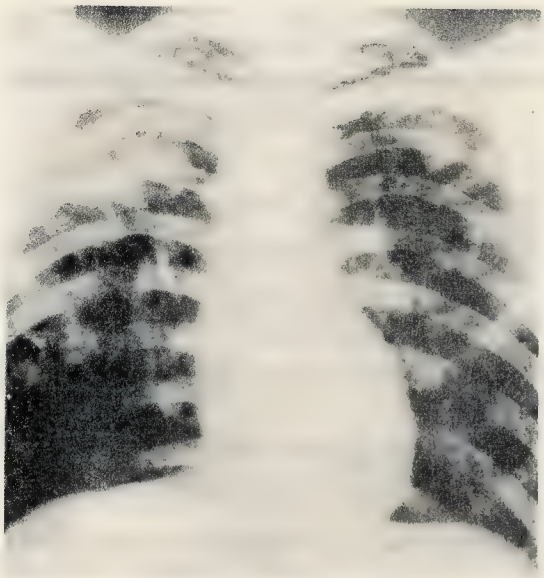


Fig. 41. Case 29. Large, confluent patches of exudative and caseous lesions in the upper two-thirds of both lungs. Cavities are seen in the right lung.

sent to Pusan. All through his illness, was frequently deprived of food and water, often for days (see Table 9).

After repatriation, still had cough with expectoration of large amount of bloody sputum, chest pain and fever. Roentgenogram of the chest (Fig. 41) disclosed large, confluent patches of exudative and caseous lesions in the upper two-thirds of both lungs. There were many cavities in the right lung. The erythrocyte sedimentation rate was 34 mm at the end of first hour. Tubercle bacilli were found in the sputum.

This case illustrates that the P.O.W. developed symptoms of pulmonary tuberculosis in the American camp following ruthless beating.

2. How they were Treated in their Illness

As tabulated above (Table 8), among the 167 patients with pulmonary tuberculosis, 46 had markedly active lung lesions. After going over the records of these 46 patients and learning in some detail what happened to them in the P.O.W. camp, one can readily understand why their diseases have reached such a serious stage of development. It is universally recognized that proper rest and good nutrition are the two basic principles in the treatment of pulmonary tuberculosis. Let us see how tuberculous cases were treated in the American P.O.W. camps. First, ration given these patients was in no way different from that given P.O.W.s in general which was extremely deficient and poor in quality (see Chapter VI), and on which even persons without sickness could not be expected to maintain minimal health. In patients with tuberculosis such deficient diet would certainly hasten the progression of the lesion and worsen the disease. Second, these seriously ill patients had no rest or other care. On the contrary, debilitated as they were, they were brutally treated and persecuted. All sorts of atrocities were perpetrated against these helpless patients, even after they had been diagnosed by camp doctors as advanced tuberculosis and had been sent to the "infirmary". In the appended table (Table 9) 30 such instances, all with markedly active pulmonary tuberculosis, are briefly recorded.

In summary, this group of tuberculous patients owed their illnesses to the conditions under which they lived as prisoners of war. Their health could not have so deteriorated had the usual considerations for P.O.W.s, as laid down in the Geneva Conventions of August 12, 1949, been given them. What has been said in the foregoing pages amply confirms the well-known fact that the American camp authorities have grossly infringed this international agreement and have willfully committed outrages on prisoners of war, not even sparing the sick and wounded.

TABLE 9. THIRTY POWs WITH MARKEDLY ACTIVE PULMONARY TUBERCULOSIS WHO WERE SUBJECTED TO BRUTALITIES DURING ILLNESS

Name	*Record No.*	*I.S.N.*	*Date of "hospitalization"*	*Brutalities*
Li Ch'un-lai	725		June 1951	1) Poison gas attack in "Infirmary" 6, Pusan, June 1952. 2) Clubbed over back and legs in "Infirmary" 5, Pusan, December 1952. 3) January 1953, solitary confinement for one month in "Infirmary" 5, Pusan, with reduced food ration to 1/3 of the usual amount.
Chang Lin-yen	717	707627	October 1952	Food ration reduced to 1/3 of the usual amount for two weeks, in Compound 10, Camp 8, Cheju Island, November 1952.
Ch'iao Yung-ts'ai	754		January 1952	1) Forced labor and beating with club in "Infirmary" 2, Pusan, April 1952. 2) Poison gas attack in "Infirmary" 2, Pusan, April 1952.
Yang Chin-ch'üan	763	717376	February 1952	Poison gas attack in "Infirmary" 6, Pusan, April 1952.
Wu San-ch'eng	767	711403	September 1951	1) Poison gas attack in "Infirmary" 6, Pusan, April 1952. 2) Deprived of food and water for 2 days in "Infirmary" 6, Pusan, April 1952. 3) Struck on the chest by a nurse in "Infirmary" 5, Pusan, March 1953. 4) Deprived of food and water for three days in "Infirmary" 5, Pusan, April 1953.
Chang Ping-jung	800	714902	June 1952	1) Twice deprived of food and water, for two and three days, respectively, in "Infirmary" 5, Pusan, February and April 1952. 2) Struck on the face and dirty water from kitchen and latrine forced down the nose and throat in the "infirmary", Koje, June 1952. 3) Twice deprived of food and water for one and three days, respectively, in the "infirmary", Koje Island, July 1952. 4) Stabbed on the right hand with the point of bayonet in "Infirmary" 5, Pusan, February 1953; scar still present. 5) Struck by large pieces of stone on the feet in "Infirmary" 5, Pusan.
Shao Chang-ken	820	713835	October 1951	1) Struck on head and face in "Infirmary" 5, Pusan, December 1952. 2) Deprived of food and water 5 times, in "Infirmary" 5, Pusan, from November 1952 to April 1953.
Li Chung-ho	821	700177	April 1952 (Pulmonary tuberculosis diagnosed by U.S. army doctor in February 1951)	1) Poison gas attack in "Infirmary" 6, Pusan, April 1952. 2) Twice deprived of food and water for five and three days, respectively, in "Infirmary" 6, Pusan, October 1952. 3) Solitary confinement for one month, inquisition followed by ruthless beating with club and kicking, in "Infirmary" 5, Pusan, February 1953. 4) Deprived of food and water for three days in "Infirmary" 5, Pusan, March 1953.
Yen Yüeh-pin	822	706235	February 1952	Deprived of food and water for four days in "Infirmary" 6, Pusan, February 1953.
Shen Ch'un-lin	825	711982	September 1951	1) Deprived of food and water for four days in "Infirmary" 6, Pusan, December 1951. 2) Deprived of food and water for more than ten days in "Infirmary" 6, Pusan, April 1952.

TABLE 9. *(continued)*

Name	*Record No.*	*I.S.N.*	*Date of "hospitalization"*	*Brutalities*
Wu Ch'eng	824		December 1952	1) Deprived of food and water for 11 days in "Infirmary" 2, Pusan, May 1952. 2) Poison gas attack in "Infirmary" 2, Pusan, May 1952.
Hsü Lung-feng	827		July 1951	Savagely clubbed in the "infirmary", Koje Island, April 1953.
Wang Hsüeh-hsin (Wang Hsiao-hsing)	842	716989	August 1951	1) Twice deprived of food and water for three and five days, respectively, in "Infirmaries" 6 and 5, Pusan, April 1952. 2) Poison gas attack in "Infirmary" 6, Pusan, April 1952. 3) Struck and kicked on chest in "Infirmary" 5, Pusan, December 1952. 4) In "Infirmary" 5, Pusan, December 1952, struck on face, and splinters inserted under finger nails with free ends of splinters burning.
Hung Hua-ch'ing	847	708234	September 1951	1) Solitary confinement for 8 days with reduced food ration in "Infirmary" 6, Pusan, October 1951. 2) Poison gas attack in "Infirmary" 6, Pusan, May 1952. 3) Deprived of food and water many times in "Infirmaries" 5, 6, and 7, Pusan, 1952. 4) Struck on chest and face in "Infirmary" 5, Pusan, March 1953.
Ke Neng-chiang	856	715495	Janupary 1952	1) Deprived of food and water for 11 days in "Infirmary" 2, Pusan, April 1952. 2) Poison gas attack in "Infirmary" 2, Pusan, April 1952.
Hsü T'ung-kuang	859	708520	February 1952	Struck on back in "Infirmary" 5, Pusan, February 1953.
Sun Pao-chü	907	712014	September 1951	1) Poison gas attack in "Infirmary" 6, Pusan, May 1952. 2) Struck on face in "Infirmary" 5, Pusan, March 1953.
Yang Chih-ho	915	700896	April 1951	Twice deprived of food and water for three and four days, respectively, in "Infirmary" 5, Pusan, July 1951.
Chao Ch'eng-kuei	918	713921	February 1952	1) Deprived of food and water in "Infirmary" 2, Pusan, April 1952. 2) Poison gas attack in "Infirmary" 2, Pusan, May 1952.
Shen Wen-ho	930	713731	October 1951	1) Poison gas attack in "Infirmary" 6, Pusan, May 1952. 2) Struck on face in "Infirmary" 5, Pusan, January 1953.
Feng Nien (Feng Jih-ch'eng)	933		December 1952 (Symptoms developed in September 1952)	Five poison gas attacks in Compound 4, Camp 3, Cheju Island and "Infirmary" 5, Pusan, 1952 and 1953.
Ch'en Ch'i-hou	935	707432	December 1951	1) Kicked on head while having hemoptysis in "Infirmary" 6, Pusan, 1952. 2) Deprived of food and water in "Infirmary" 5, Pusan, March 1953.
Nung Wei	937	703522	December 1952 (Pulmonary tuberculosis diagnosed in November 1951)	1) Ruthlessly beaten with club in Compound 86, Koje Island, March 1952. 2) Forced labor for more than 10 days in Compound 8, Camp 8, Cheju Island, July 1952 3) Poison gas attack in the same Compound as above, August 1952.
Li T'ien-Shih	941	709964	August 1951	1) Struck on head in "Infirmary" 5, Pusan, January 1953. 2) Deprived of food and water for three days in "Infirmary" 5, Pusan, April 1953.
Ch'eng Fu-ming	1069	701845	April 1952	Poison gas attack in "Infirmary" 7, Pusan, August 1953.

TABLE 9. *(continued)*

Name	*Record No.*	*I.S.N.*	*Date of "hospitalization"*	*Brutalities*
Li Ch'ang-ts'ai	1081	701990	May 1952	1) Poison gas attack in "Infirmary" 4, Pusan, May 1952. 2) Poison gas attack in Compound 9, Camp 8, Cheju Island, August 1952.
Wang Yi-hua	1116	709710	November 1951	1) Savagely beaten with club in "Infirmary" 2, Pusan, December 1951. 2) Poison gas attack in "Infirmary" 6, Pusan, May 1952. 3) Poison gas attack in "Infirmary" 5, Pusan, August 1953.
Chang Chih-fang	1149	702990	May 1951	1) Poison gas attack in "Infirmary" 1, Pusan, July 1953. 2) Poison gas attack in "Infirmary" 7, Pusan, July 1953. 3) Ruthlessly beaten with club in "Infirmary" 7, Pusan, July 1953.
Chen Hsiang-shan	1154	718589	August 1952	1) Poison gas attack in Compound 10, Camp 8, Cheju Island, August 1952. 2) Poison gas attack in Compound 7, Camp 8, Cheju Island, August 1953.
Chang Ch'eng-kuo	1159	705118	June 1951	1) Struck on face in the "Infirmary", Koje Island, June 1951. 2) Struck on chest by a nurse, while being transferred from Koje to Pusan, July 1951. 3) Poison gas attack in "Infirmary" 6, Pusan, August 1951.

CHAPTER VIII

NON-TUBERCULOUS CHRONIC RESPIRATORY DISEASES

For the sake of convenience, we have classified non-tuberculous chronic respiratory diseases as having the following features:

1. Respiratory symptoms of more than three months' duration;
2. Pulmonary tuberculosis having been ruled out by roentgenological examination;
3. Relevant abnormal physical findings;
4. Abnormal x-ray findings, such as pulmonary emphysema, increase in pulmonary markings, presence of bronchiectasis, etc.

The cases of non-tuberculous respiratory diseases herein dealt with all had the above specific features 1 and 2, including, in some cases, 3 or 4. Pulmonary paragonimiasis was excluded by proper sputum examination. There were in all 292 returnees afflicted with diseases in this category, and they constituted 18 per cent of the sick and wounded returnees and more than one half of the total number of medical cases. Such an unusual preponderance of chronic respiratory diseases must have its reasons.

1. Predisposing Causes

The causative factors of respiratory diseases are many, the most important being changes in the individual's internal and external environment. Our patients practically all dated their illness as from their capture, the majority of them having never previously had respiratory symptoms of any appreciable duration. Those with histories of winter cough were also symptom-free at the time of capture. The onset of symptoms in practically all these patients was related in one way or another to their P.O.W. camp life, horrible living conditions, inhumane treatment, brutalities, mental sufferings, etc. Take physical tortures alone for example. The shocking cruelties practised in the camps, such as beating, poison gas, exposure to cold, forced labor, solitary confinement, immersion in cold water (up to the knee with the body stripped naked), forcing of pepper infusion down the nose and throat, etc., were the precipitating cause of the symptoms in 46 per cent of the cases. Moreover, after the onset of their illnesses, these P.O.W.s were still subjected to attacks by poison gas and other brutalities. Forced labor was continued and they had to subsist on a terribly insufficient diet. In the face of these conditions, so detrimental to physical and mental health, it is no wonder that chronic respiratory diseases prevailed in the American P.O.W. camps at such an alarming rate.

The following cases illustrate these facts:

> Illustrative Case 30: Record No. 879, Shih Shih-hung, I.S.N. 780101. Male, 24 years of age. Date of capture, December 8, 1950. No respiratory symptoms prior to capture. One day in April 1952 was badly beaten by 4 American-South-Korean soldiers. Developed severe cough after the torture with large amount of sputum. Had also hemoptysis, chest pain and general weakness. Was told to have pulmonary tuberculosis by an American army doctor after a physical examination. In June 1952, was sent to compound 10, Camp 8 of Cheju Island, to stay with tuberculous

patients. No treatment of any form was given.

After repatriation still had cough and chest pain with large amount of sputum. Sputum was sometimes blood-streaked and foul in odor. Examination of the chest revealed no abnormal signs. Sputum showed no tubercle bacilli. Roentgenogram of the chest (Fig. 42) revealed no parenchymal changes and no evidence of pulmonary tuberculosis. There was increase of lung markings, compatible with non-tuberculous chronic respiratory infection.

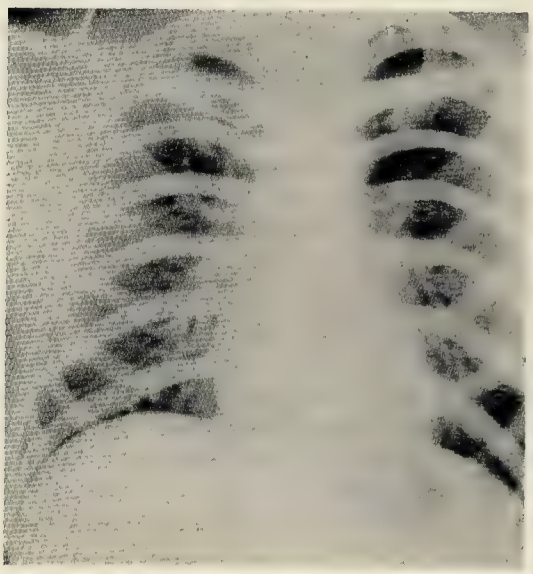


Fig. 42. Case 30. No evidence of parenchymal lesion including tuberculosis. Lung markings are generally increased, compatible with chronic respiratory infection.

This case illustrates that respiratory symptoms developed after physical torture and had become chronic.

ILLUSTRATIVE CASE 31: RECORD NO. 1018, TENG HSING-TSAI, I.S.N. 713881. Male, 24 years of age. Date of capture, May 26, 1951. Had no respiratory symptoms whatsoever prior to capture. In October 1951, when weather was already cold, was tortured by exposure to cold with the body stripped to the waist. This lasted for five and half days. Cough developed directly after the torture. For several months sputum was dark in color and frequently blood streaked. Had also vague chest pain, night sweats, loss of weight and general weakness. Was told to have pulmonary tuberculosis by an American army doctor after a physical examination and was sent to compound 10, Camp 8 of Cheju Island to be segregated with tuberculous patients. No proper treatment of any kind was given.

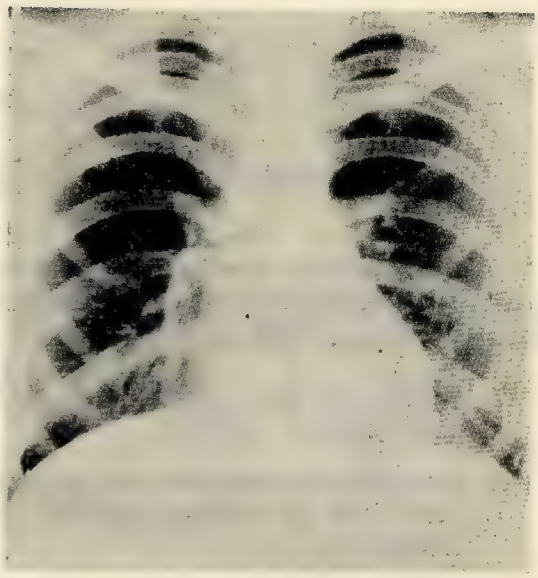


Fig. 43. Case 31. No evidence of tuberculosis. Lung markings are thickened, especially in the lower lung fields.

After repatriation still had cough with dark colored sputum, frequently blood-streaked. Physical examination of the chest was negative. Sputum showed no tubercle bacilli. Roentgenogram of the chest (Fig. 43) revealed no evidence of tuberculosis. There was increase in lung markings bilaterally, especially in the lower lung fields, compatible with the diagnosis of non-tuberculous chronic respiratory infection.

This case illustrates that respiratory symptoms developed after prolonged exposure to cold and became chronic.

ILLUSTRATIVE CASE 32: RECORD NO. 804, CHANG CH'ANG-FU, I.S.N. 731828. Male, 30 years of age. Date of capture, Jan. 7, 1951. Since 1945 had had winter cough, subsiding in summer. After cap-

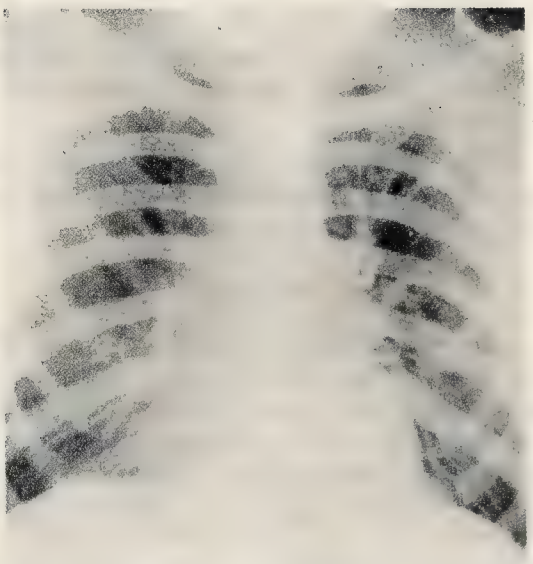


Fig. 44. Case 32. Lung markings are generally thickened. No evidence of parenchymal lesion.

ture cough persisted throughout the whole year. Had repeated maltreatment and tortures in the form of clubbing, forced labor and deprivation of food and water. On July 2, 1952 following a poison gas attack (in compound 1, Camp 8, Cheju Island) cough got worse with daily expectoration of more than 50 mouthfuls of dark sputum, frequently blood-streaked. There was bilateral chest pain, loss of appetite and body weight, lassitude and general weakness. Roentgenological examination of the chest was made but result was not told the patient. He was sent to stay with tuberculous patients.

After repatriation, cough abated with about 10 mouthfuls of sputum daily. Examination of the chest revealed hyperresonance and dry and wheezing rales over lung bases. Acid-fast bacilli were not found in sputum. Roentgenogram of the chest (Fig. 44) showed increase in lung markings but no evidence of parenchymal lesion.

This case illustrates exacerbation of respiratory symptoms following maltreatment and gas poisoning.

ILLUSTRATIVE CASE 33: RECORD NO. 787, SUN KE-YI, I.S.N. 718251. Male, 30 years of age, captured on August 24, 1951. Had had occasional cough since 1946 but was free from cough at the time of capture. On September 18, 1951, he was first beaten and then fastened to a camp cot for inquisition, badly injuring the left arm (now with a scar left). Pepper infusion was forced down his nose and throat, in which process he lost consciousness. Next morning, spat a large amount of blood followed by blood streaked sputum. Cough got worse with expectoration of yellowish sputum. Had bilateral chest pain, fever, loss of weight, etc. In November 1951, roentgenological examination of the chest was done and he was told to have "pulmonary disease". Was sent to Pusan and "hospitalized" together with tuberculous patients, later transferred to compound 10, Camp 8 of Cheju Island.

After repatriation, cough was still bad with profuse foul sputum, sometimes blood streaked. Chest pain remained. Examination of chest showed dry and moist rales. Roentgenogram of the chest (Fig. 45) revealed marked generalized thickening of

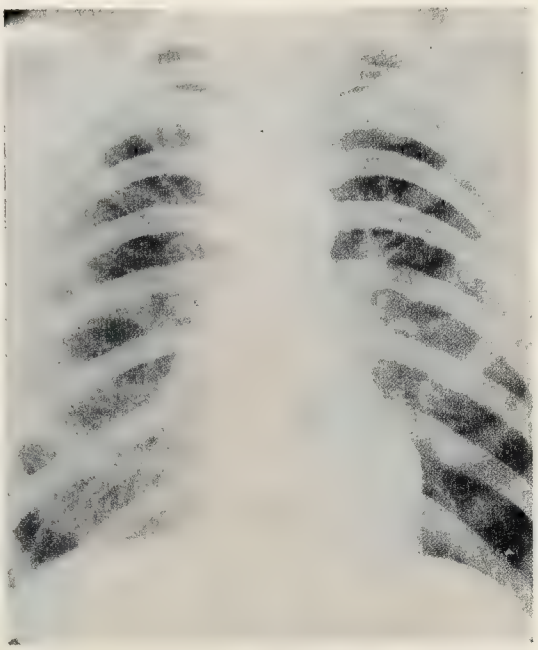


Fig. 45. Case 33. Lung markings are generally exaggerated with no evidence of parenchymal lesion.

lung markings and no evidence of parenchymal lesion.

This case illustrates that respiratory symptoms started after torture and persisted two years after the onest.

ILLUSTRATIVE CASE 34: RECORD No. 893, SU CHUN-YU, I.S.N. 732659. Male, 26 years of age, captured on Oct. 15, 1951. Was robust before capture. In February 1952 while in Compound 86, Koje Island, was repeatedly grilled whether he was a member of the Communist Party. He was tortured and badly beaten with clubs on the chest and abdomen, which caused loss of consciousness. On return to his camp, felt pain in the chest and abdomen. Developed a cough which persisted and became progressively worse. Had fever, chilliness and night sweats. In March 1952, had hemoptysis for two days. After a roentgenological examination of the chest, was told to have pulmonary tuberculosis. Thoracentesis was done twice, several cupfuls of bloody fluid aspirated each time.

After repatriation cough persisted with decreased severity. Chest pain remained. Appetite and body weight increased. Physical examination of the heart and lungs showed negative findings. Roentgenogram of the chest (Fig. 46) showed tenting of right diaphragm. No parenchymal change.

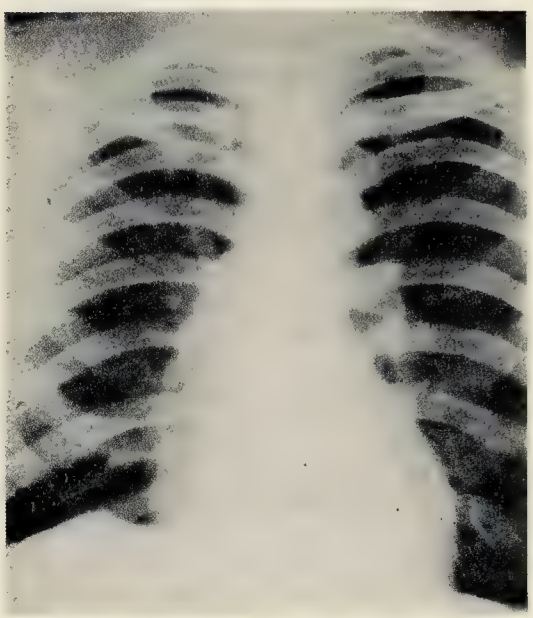


Fig. 46. Case 34. Lungs clear. There is tenting of the right leaf of the diaphragm.

This case illustrates that respiratory symptoms and hemothorax developed after physical violence to the chest.

2. Diagnosis

From the listed symptoms in Table 10, one is led to the conclusion that these cases at the beginning must have been acute respiratory infections or else injuries inflicted on the respiratory system. For instance, exposure to cold might have predisposed to pneumonia or acute bronchitis, inhalation of asphyxiating or other obnoxious gases could be followed by acute tracheobronchitis and pulmonary edema which in turn might lead to bronchopneumonia or lung abscess, external violence to the chest could result in pneumothorax, hemothorax, or pneumonitis. These acute conditions, if properly treated in the early stage, need not be always serious. But if on the other hand the bodily resistance to infection were low, or the environmental conditions were bad, as was the case with these patients, the symptoms and the underlying disease process then would not abate, but would be aggravated and become chronic.

TABLE 10. SYMPTOMS OF 292 CASES OF NON-TUBERCULOUS CHRONIC RESPIRATORY DISEASES

Symptoms	*In P.O.W. camp*		*At present†*	
	Number	*Percentage**	*Number*	*Percentage*
Cough	288	99.0	247	84.6
Hemoptysis or blood-tinged sputum	130	44.5‡	33	11.3
Profuse expectoration	118	40.4	26	8.9
Chest pain	205	70.2	129	44.2
Fever	163	55.8	69	23.6

* Percentage of the total number of 292 cases.

‡ Hemoptysis in 23.3 per cent.

† Altogether 262 patients, or 89.7 per cent, have symptoms at present.

The sequence of events in these cases may be surmised as follows: Clinically, it was improper treatment or lack of treatment, particularly failure to control the infection, which led to the persistence of inflammation, while, pathologically, long continued edema of the mucous membrane of the bronchial tree resulted in retention of the exudate, formation of granulation tissue and cicatrix, weakening of the bronchial wall, involvement of the lung parenchyma, culminating in due course in bronchiectasis, pulmonary fibrosis, pulmonary emphysema and other irreparable damages. The horrible conditions and the irresponsible attitude of the American medical staff in the P.O.W. camps were certainly factors that favored these changes, especially in view of the fact that the P.O.W.s were not only deprived of proper rest and reasonable treatment but were subjected to torture and privation. Consequently, even after their repatriation and inspite of every care in our own hospitals, 90 per cent of this group with chronic respiratory diseases still suffer from residual symptoms of varying intensity (Table 10), many still expectorating blood or blood-tinged sputum, and nearly half of them complaining of pain in the chest. These are sufficiently clear indications that their respiratory diseases had long become chronic, and in some cases had already turned into chronic suppurative lesions, such as bronchiectasis or lung abscess.

The following two cases may serve as examples:

ILLUSTRATIVE CASE 35: RECORD NO. 849, CHANG TE-HAI, I.S.N. 718734. Male, 23 years of age, captured on Oct. 11, 1951. Had cough 4 years prior to capture. After imprisonment developed a cough which got progressively worse and was accompanied by shortness of breath. Expectorated large amount of foul greenish sputum. There was pain in upper chest. Occasionally had fever. After a roentgenological examination of the chest, was told to have pulmonary tuberculosis and was sent to stay with tuberculous patients. Maltreatment and violences continued, including forced labor, beating, kicking, deprivation of food and water, etc.

After repatriation still had cough and shortness of breath. Sputum was still foul but decreased in quantity. Still had occasional fever. Physical examination of chest revealed wheezing rales and bronchial breath sound over left lower back. Tubercle bacilli not found in sputum. Roentgenogram of the chest (Fig. 47) revealed general increase of lung markings, mottled clouding in the right upper and both lower lung fields and honey-comb appearance in lung bases.

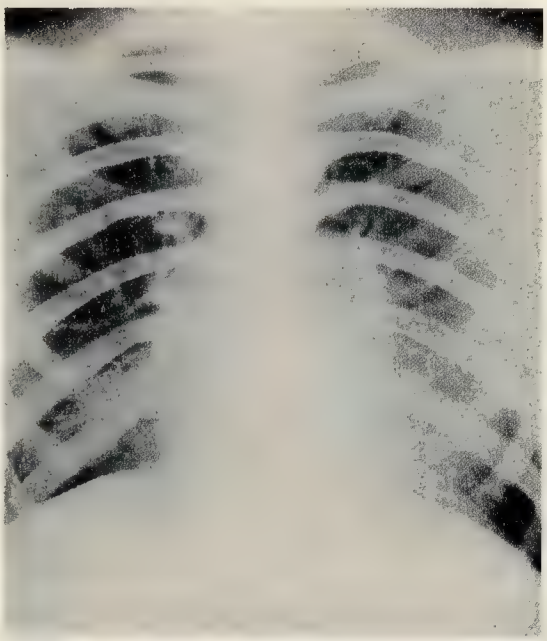


Fig. 47. Case 35. Lung markings are generally increased. Mottled clouding is noted in the right upper and both lower lung fields. Honey-comb appearance in lung bases.

This case illustrates that chronic respiratory infection developed to bronchiectasis.

ILLUSTRATIVE CASE 36: RECORD NO. 308, KAO TZE-YI, I.S.N. 709117. Male, 28 years of age, captured on May 28, 1951.

Had some cough in the beginning of 1951. Seventeen months after capture, again developed cough with large amount of foul, greenish sputum. Was confined to

bed with right-sided chest pain and afternoon fever. During the course of the illness, was subjected to poison gas attacks. Began to have hemoptysis one month after the latter outrage. No treatment of any kind was given in the P.O.W. camp.

After repatriation, cough with profuse sputum remained and had afternoon fever. Physical examination of chest showed dullness over the right middle lung with diminution of breath sounds. No rales. No tubercle bacilli in sputum. Roentgenogram of the chest (Fig. 48) showed a large area of parenchymal infiltration in the right lower lung field posteriorly with a big cavity, 2 x 4 cm, in its centre, and pleural thickening and adhesions on the right side.

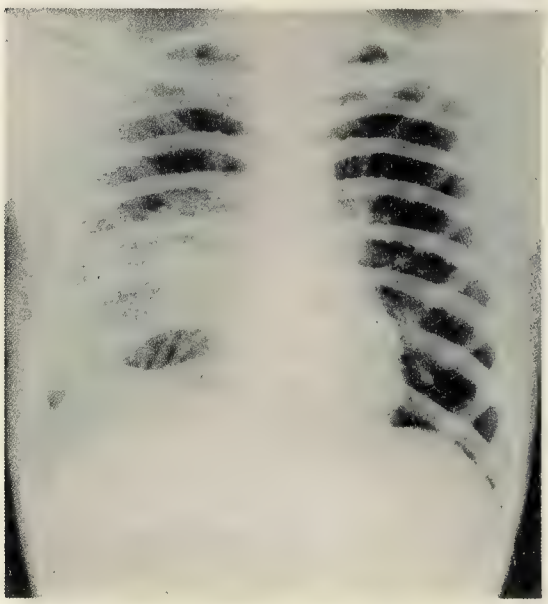


Fig. 48. Case 36. Large area of parenchymal infiltration in the right lower lung field posteriorly with a big cavity, 2 x 4 cm, in its center. Pleural thickening and adhesions on the right side.

This case illustrates that respiratory infection was aggravated after poison gas attacks and with lack of treatment eventually resulted in lung abscess.

In regard to objective findings, more than a quarter of the cases (28.1 per cent) still show physical signs in the chest, such as rales, or change in percussion note or breath sound. In some, the roentgenograms of the chest, while excluding tuberculosis reveal pulmonary emphysema, suggestive appearance of bronchiectasis or increase in pulmonary markings.

In view of the above, we deem it an indisputable fact that these returnees are sufferers of chronic respiratory diseases contracted and propagated during their internment in the American P.O.W. camps.

3. Treatment in the Camps

The management of these cases of respiratory diseases on the part of the camp authorities was also entirely contrary to basic medical principles. About one-third of the patients never received any medical care whatsoever and very few were benefited by antibiotics or chemotherapy. As has been pointed out before, many of them had to serve forced labor and were victims of persecution and physical injury. Almost two-thirds were summarily and erroneously diagnosed as pulmonary tuberculosis, and without further examination were condemned to segregation among tuberculous cases. This latter type of "isolation" was imposed on 64.3 per cent of these non-tuberculous patients, and sometimes even persons without disease were likewise confined. On the other hand, some tuberculous patients were ignored and not properly isolated. The conditions in the camp "infirmary" were also appallingly bad. Patients were thrown together without consideration of diagnoses or severity of the diseases, often tuberculous cases with the non-tuberculous. The facilities were extremely poor and there were no real isolation precautions or disinfection to speak of. It seemed that the camp doctors simply segregated all prisoners with respiratory symptoms for the sake of convenience, with no consideration whatsoever of the possible risk of cross infection between patients. Under such circumstances, not only tuberculosis could be contracted from one another but also other bacterial and viral infections. In this way, these

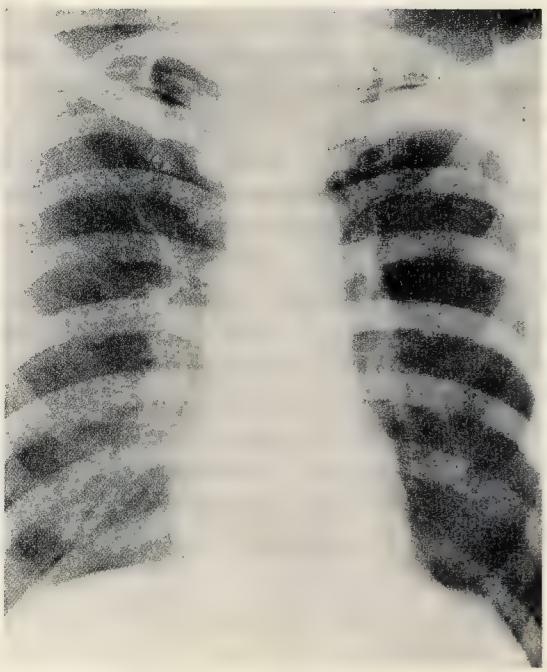


Fig. 49. Case 37. Lung markings are prominent. Transparency of lung fields increased more markedly on the left side. No parenchymal lesion.

patients in addition to their diseases could develop secondary infections which served to aggravate the symptoms, propagate the disease process and conduce to chronicity. The harm thus caused these patients is truly inestimable.

The following cases illustrate some of the above facts:

ILLUSTRATIVE CASE 37: RECORD NO. 887, CH'UAN HAN-CHI, I.S.N. 717283. Male, 33 years of age, captured on June 17, 1951. Had no respiratory symptoms whatsoever before capture. Cough started in August 1951 with large amount of whitish sputum, sometimes blood-streaked. Felt pain in left chest. Frequently had spells of fever. Examined by an American army doctor and was told to have far advanced pulmonary tuberculosis. Was sent to Pusan for isolation as a case of pulmonary tuberculosis. In November 1951 and February 1952 received tortures with severe beatings, every time after the torture symptoms got worse.

After repatriation cough remained with profuse sputum and night sweats. Physical examination revealed diminution of breath sounds over left lower lung. Tubercle bacilli not found in sputum. Roentgenogram of the chest (Fig. 49) showed prominent lung markings, increased transparency of lung fields, more marked on the left side, and absence of parenchymal lesion.

This case illustrates that non-tuberculous patient, without proper examination and diagnosis, was isolated as a case of tuberculosis.

ILLUSTRATIVE CASE 38: RECORD NO. 832, LI HSIAO-HUNG. Male, 22 years of age. Captured on December 26, 1951. No respiratory symptom before or after cauture. After the capture, he was questioned and tortured, tied down to a table and badly whipped. In July 1952 at the time of "screening" sustained shrapnel wound of left arm and was deprived of food and water for 7 days. No cough at this time, but following a chest examination by army doctor, was told to have pulmonary tuberculosis. Was sent to compound 10, Camp 8, Cheju Island for segregation with tuberculous patients. Maltreatment and violence

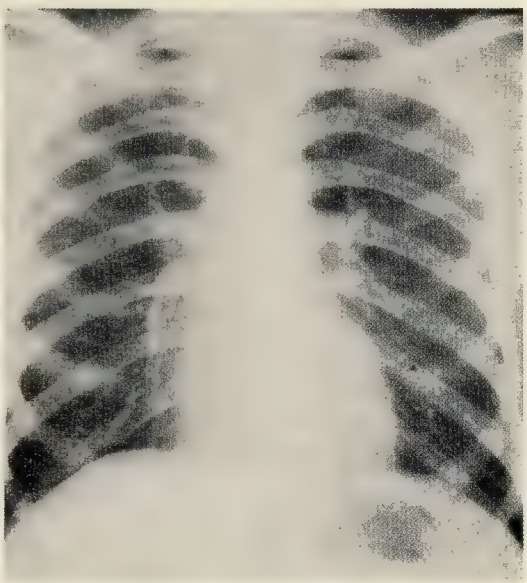


Fig. 50. Case 38. Lungs clear. Markings in the right upper are prominent.

continued—beating, kicking, poison gas, etc. Cough developed prior to repatriation.

After repatriation, cough with sputum persisted. Also had feverishness, anorexia and loss of weight. Examination showed diminished breath sounds in the right upper chest. Tubercle bacilli were not found in sputum. Roentgenogram of the chest (Fig. 50) revealed no parenchymal lesion in the lungs but prominent markings in the right upper lung field.

This case illustrates that P.O.W. without respiratory symptoms was isolated as a case of pulmonary tuberculosis and that during "hospitalization" repeated maltreatment and violences finally resulted in development of cough and other symptoms.

In summarizing the conditions of the 292 returnees now suffering from non-tuberculous chronic respiratory diseases, it should be pointed out that the majority are already disabled by their illnesses and that damages done to them are no less serious than dismemberment or surgical mutilations, the difference being only with the way the damages were brought about. It is certain that in our present cases the sufferings of the victims are more prolonged and distressing than those described in the section of this Report dealing with surgical conditions. These patients are living evidences of the outrageous crimes perpetrated on the P.O.W.s by the American camp authorities.

CHAPTER IX

MEDICAL EVIDENCES OF VIOLENCE COMMITTED AGTINST P.O.W.s BY U.S. ARMED FORCES

Among the 1,609 returnees covered in this report, almost all of them had suffered some sort of violence after being captured. The weapons used in committing these crimes by American troops included wooden or steel rods, bayonets, machine guns, hand grenades, gas bombs, armoured cars, tanks and such cruel means as burning, exposure to cold, electric torture, forcing of water through the nostrils, and slashing. It is the purpose of this chapter to furnish factual evidences from the medical point of view and to prove that the commitment of brutalities by U.S. troops is undeniable. The details that follow are divided into two parts:

1. Effects of U.S. Militarists' Brutalities on P.O.W.s' Diseases

A detailed investigation has been made concerning the 350 medical cases of the first group of repatriates and the brutalities to which they had been subjected, either as causative or aggravating factors, in relation to their diseases. In the course of our investigation, we found that 347 (99 per cent) of these returnees, while they were P.O.W.s, were brutally treated by U.S. militarists, that each of them was more than once tortured, and that several forms of torture were used. The following table (Table 11) lists the cruelties these 350 men were made victims of before and during their sicknesses:

TABLE 11. VARIOUS FORMS OF BRUTALITY INFLICTED ON 350 P.O.W.s

Forms of cruelties		*Poison gas*	*Beating with a club*	*Kicking and striking*	*Deprivation of food and water*	*Crawling on all fours*	*Forced labor (1)*	*Solitary confinement (2)*	*Electric torture*	*Stabbing*	*Miscellaneous (3)*	*Total*	*Average number of forms of cruelties inflicted on each P.O.W. (5)*
Number of P.O.W.s subjected to cruelties	Before sickness	39	117	143	27	52	54	8	12	2	6	460	
	During sickness	274	118	107	136	75	44	30	6	8	10	808	
	TOTAL	313	235	250	163	127	98	38	18	10	16	1268	3.6
Percentage (4)		89.4	67.1	71.4	46.5	36.3	28.0	10.8	5.1	2.8	4.6		

Notes: (1) Forced labor: Carrying stones and wood and unloading oil drums from war vessels.

(2) Solitary confinement: Being locked up in a dark room without window or ventilation.

(3) "Miscellaneous" included immersion of naked body in water up to the knees, burning of the skin and pubic hair, forcing of water and pepper solution through the nostrils, insertion of bamboo splinters under the nails, and scorching with hot iron.

(4) "Percentage" means percentage of P.O.W.s on whom each form of cruelty was inflicted.

(5) With each form of cruelty, the majority of P.O.W.s tortured received the outrage more than once.

It can be seen from the above that a great many P.O.W.s were outrageously treated and tortured during their illnesses. The effect of these brutalities on the P.O.W.s' diseases are given in the chapters dealing with medical cases.

Of all these atrocities, the use of poison gas had the worse effect on the sicknesses of the P.O.W.s. Among the 350 medical cases, 313 (89.4 per cent) had been attacked with poison gas. Some of the sick and wounded were attacked with poison gas as many as 31 time; and generally speaking each person was subjected to this horrible experience from three to ten times.

2. Wounds and Disabilities Caused by Brutalities

Careful inquiries and detailed examination of 1,172 wounded returnees have disclosed the fact that 76 of them (6.5 per cent) had definite signs of having been injured in the P.O.W. camps or hospitals after repeated brutalities on the part of American military and medical personnel. Among these 76 cases, injuries inflicted on 49 of them can be identified now by the presence of scars over various parts of the body, but 27 of the victims have been crippled and partially or entirely incapacitated. The delay in treatment of the wounded aggravated the seriousness of the disability. It should be emphasized that among the 76 wounded, 40 were injured in the American prisoner camps and the rest received their injuries in the American prison hospitals or on the way to the hospitals.

a. *Manhandling of sick and wounded prisoners.* The P.O.W.s were generally manhandled by the American military; even the seriously sick and wounded were not exempted. Such brutalities frequently resulted in more injuries as the following examples show:

ILLUSTRATIVE CASE 39: RECORD NO. 103, LIU LING (ALIAS, LIU CH'ANG-YUAN), I.S.N. COULD NOT BE REMEMBERED. Gunshot fracture of left humerus, October 27, 1951. Was captured on the day he was wounded. No treatment was given but instead his wrists were tied behind his back with electric wire. He was then forced to walk for a distance of about five kilometers, the wire was finally untied by his comrades. His left hand became swollen, cold and numb. The condition turned steadily worse and in about 20 days after he was wounded the forearm became blackish. Subsequently the limb was amputated and later re-amputated (Fig. 51).

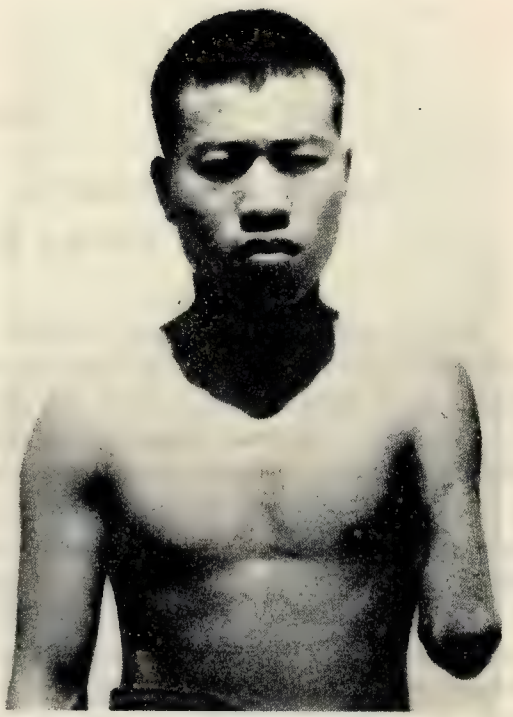
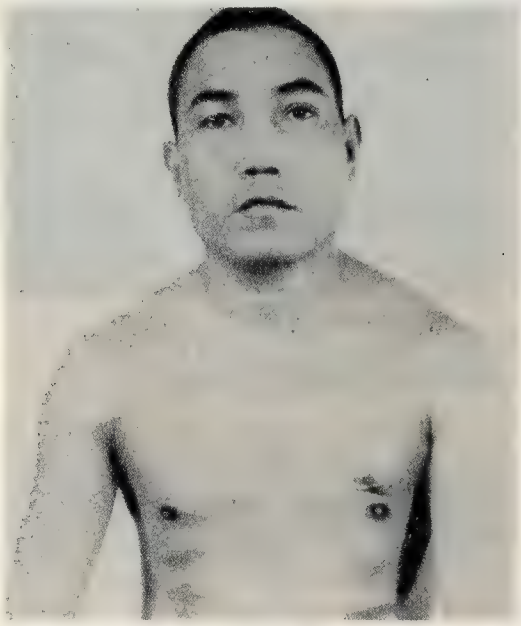


Fig. 51. Case 39. Gunshot fracture of left humerus. His wrists, when he was captured, were tied with electric wire behind his back, resulting in gangrene of the left hand and forearm for which amputation was done.

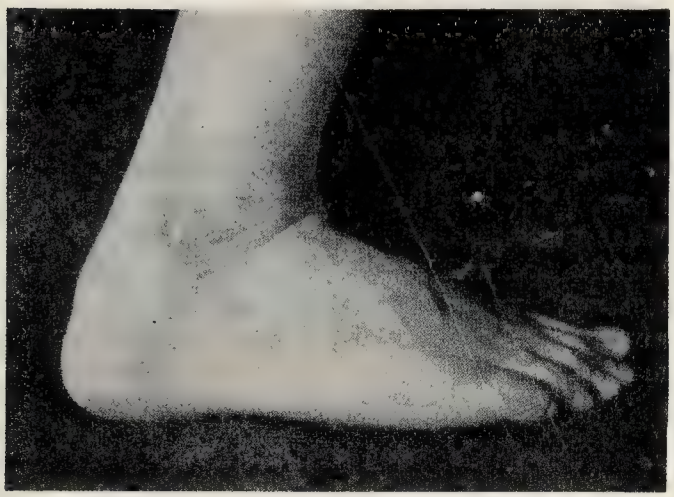
ILLUSTRATIVE CASE 40: RECORD NO. 1475, YANG CH'ING-FU, I.S.N. 733236. Received shell wound of the left side of chest (complicated by hemothorax) and gunshot wound of right shoulder on June 16, 1953. He was captured one hour after being wounded. The American military com-

pelled him to walk, but being unable to do so because of extreme weakness, he was dragged along on the ground for more than one kilometer. As a result, his occipital region, back, right heel and right external malleolar region were badly lacerated (Fig. 52A, 52B and 52C).



A

B



C

Fig. 52. Case 40. Shell wound of the left side of chest and gunshot wound of right shoulder. After capture, being unable to walk, he was dragged along on the ground for more than one kilometer. Photos showing scars over occipital region, right heel and right external malleolar region.

ILLUSTRATIVE CASE 41: RECORD NO. 1024, HSIEH CH'ENG-CHIEN, I.S.N. 715613. When Hsieh Ch'eng-chien underwent general physical examination in China in 1949, the vision of both his eyes was found normal. In April 1951, he was taken prisoner at the central front in Korea. He was at first kept in Koje but was sent in June 1952 to Cheju Island No. 8 P.O.W. camp. During his stay in that camp he was fed with nothing but coarse barley and turnip soup. He constantly suffered from abdominal pain and diarrhea and his health became very poor. He repeatedly asked the American military medical officers for examination and treatment but each time he was refused. In July 1952, he was forced by an American soldier in the camp to carry firewood; but when he could not walk fast enough on account of the heavy load and his poor health, the American soldier struck him with a big piece of wood across his left cheek and eye. He immediately fell and lost consciousness. When he came to consciousness, he felt that his left eye was very painful. After two requests were made for medical attention, an American medical officer came on the next day and gave a tube of whitish ointment to be applied once a day.

A month and a half later, the symptoms of irritation disappeared, but a whitish opacity was noticed in his left cornea and vision was much impaired.

On examination in September, 1953, after his repatriation, the vision of his left eye was finger-counting at about one foot. Over the central part of his left cornea there was an adherent leucoma with a diameter of about 5 mm and the tension of the eyeball was elevated (Fig. 53).

Fig. 53. Case 41. Photo showing leucoma adherens of the left eye caused by brutal assault of an American soldier.

Comment: These cases illustrate how the American armed forces treated the sick and wounded prisoners. In Case 39, instead of immobilizing a broken arm, they tied the prisoner's wrists behind his back. This evidently caused injury to the blood vessel by the displaced bone ends and consequently gangrene of the forearm. In Case 40, instead of carrying the seriously wounded captive in a stretcher, they dragged him along on the ground for a long distance until he was badly bruised, and in so doing they also caused more damage to the wounds the victim already had. Case 41 shows that this P.O.W. had been constantly ill and weak and underfed. When he suffered from abdominal pain and diarrhea, no medical attention was given. Moreover, he was forced to work. What was worse, after he was subjected to brutal action which seriously injured his left eye, no prompt and adequate treatment was given, thus resulted in his left eye going almost blind.

b. *Forced interrogation.* In violation of the provisions of the Geneva Conventions, the American military interrogated nearly all of the P.O.W.s. In the course of questioning, various brutalities were inflicted on P.O.W.s as shown in the following cases:

ILLUSTRATIVE CASE 42: RECORD NO. 105, HAO TUAN-HO (ALIAS, TSAI SHOU-CHUNG), I.S.N. COULD NOT BE REMEMBERED. Compound fractures of lower third of the left femur and both bones of the left leg due to shell wounds in November, 1951; wounded and captured on the same day. No treatment of any kind was instituted, and instead interrogation was held immediately. During questioning, further injury was inflicted on the already wounded left thigh by beating with a piece of heavy wood. After he was struck some twenty times the victim became unconscious. He was resuscitated by sprays of cold water, and on recovery the beating was continued until he again lost consciousness. Two days later black areas started to appear in the left thigh below the original wound. The limb was then amputated and later re-amputated (Fig 54).

ILLUSTRATIVE CASE 43: RECORD NO. 787, SUN K'E-YI, I.S.N. 718251. Captured on August 24, 1951, without previous combat wound. Interrogation held on September 18, 1951. The captive was tied with electric wire to a canvas cot. Pepper water was forced into the nostrils and then drained out by squeezing the abdomen with a piece of wood and by

hanging the patient upside down. As torturing went on, the victim became unconscious several times. Today, scars caused by constriction of the electric wire can still be discerned over the left arm (Fig. 55).

Comment: In Case 42, as a result of violence inflicted on this already badly wounded captive, serious disability and irreparable damage were done.

In Case 43, the patient survived the repeated tortures but he became seriously ill. He expectorated blood on seven occasions after his ordeals. The scar over the left arm is a strong evidence of American brutality.

c. *Forcible "screening."* In an attempt to detain the Chinese P.O.W.s, the American military forced the captives to be tattooed with anti-Communist slogans and with insults to the Chinese and Korean governments and leaders. Those who resisted were thrown to the ground, beaten half to death and tattooed while insensible, in the presence of their fellow prisoners. A few of the returnees were tattooed at the end of the anesthesia and operation, when they were yet extremely weak or even unconscious. Among them was Kuo Liu-ken, Record No. 96, I.S.N. 733000, whose right arm was tattooed with nine Chinese characters while he was being sent back to ward on a stretcher.

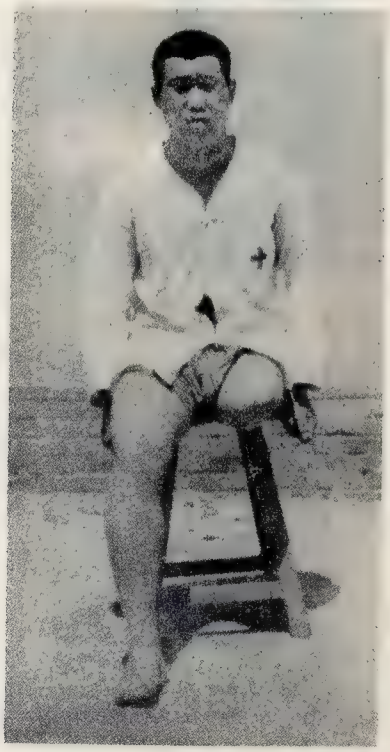


Fig. 54. Case 42. Compound fractures of lower third of the left femur and both bones of the left leg. Interrogation was held immediately after capture. The already wounded left thigh was beaten repeatedly with a heavy wooden rod, resulting in gangrene of the left leg for which amputation was performed.

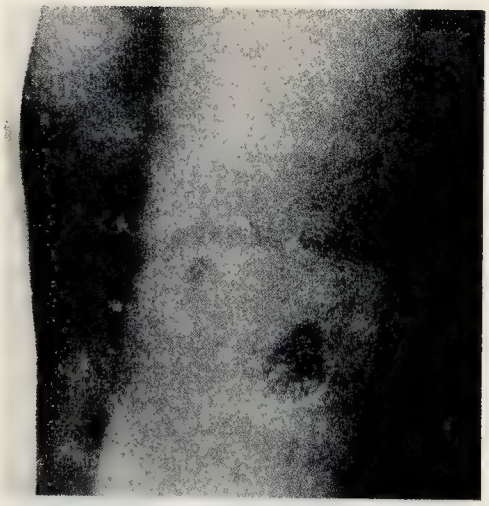


Fig. 55. Case 43. During interrogation, the captive was tied down with electric wire to a canvas cot; later hanged upside down to drain out the pepper water previously forced through the nostrils. Photo showing scar over left arm caused by constriction of the electric wire.

Among the 76 returnees wounded through brutalities of the U.S. military, 12 of them were injured on the occasions of forcible "screening." Two cases are cited below for illustration:

ILLUSTRATIVE CASE 44: RECORD No. 1368, HU TEH-CHUNG, I.S.N. 712968. Received multiple shell wounds over the whole body during forcible "screening." The scars are at present clearly discernible (Fig. 56).

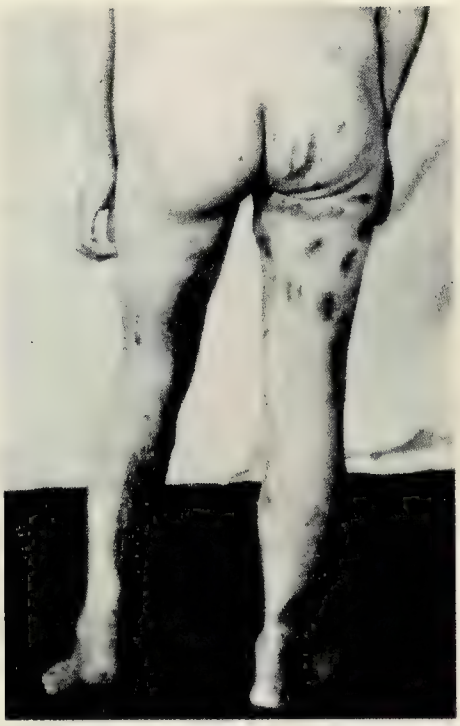


Fig. 56. Case 44. Received multiple shell wounds over the whole body during forcible "screening." Photo showing scars over both lower extremities.

ILLUSTRATIVE CASE 45: RECORD NO. 122, HSU CH'ENG-KAO (ALIAS, HSU PAO-K'UN AND CHAO T'IEN-SHENG), I.S.N. 730767. He was severely burned over his neck and both hands and was afterwards captured in March, 1951. At the end of 1951, Kuomintang agents forced him to be tattooed with anti-Communist slogans on his left arm. When the so-called "screening" was carried out on April 8, 1952, the captive again insisted on returning to his mother-country, whereupon the American military cut off with a knife the flesh on the left arm bearing the tattoo marks (Fig. 57) and showed it to his fellow prisoners threatening what might similarly happen to them if they preferred to return to their mother-country.

d. *Massacre on October 1, 1952.* When the Chinese P.O.W.s hoisted the Chinese national flag in celebration of the National Day on October 1, 1952, in Compound 7, No. 8 P.O.W. camp, on Cheju Island, a great number of them was wounded and killed by American armed forces. Among the 76 returnees injured and disabled by the violent conduct of American troops, 17 were badly hurt during that incident. Two cases are cited below to serve as evidence of the violence:

ILLUSTRATIVE CASE 46: RECORD NO. 26, HU TIEN-YIN (ALIAS, LI YUEH-LIANG), I.S.N. 731113. At the time of the massacre, he sustained gunshot fractures of his left temporal and parietal bones. At present, there is a big defect in the skull (Fig. 58A and 58B). The victim has since been seriously disabled because of motor aphasia.

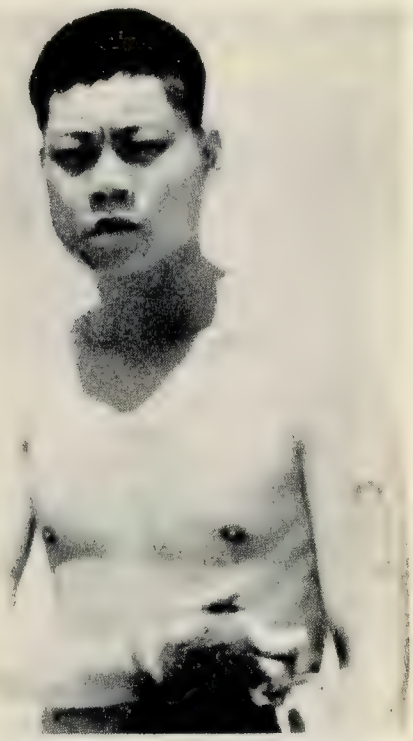
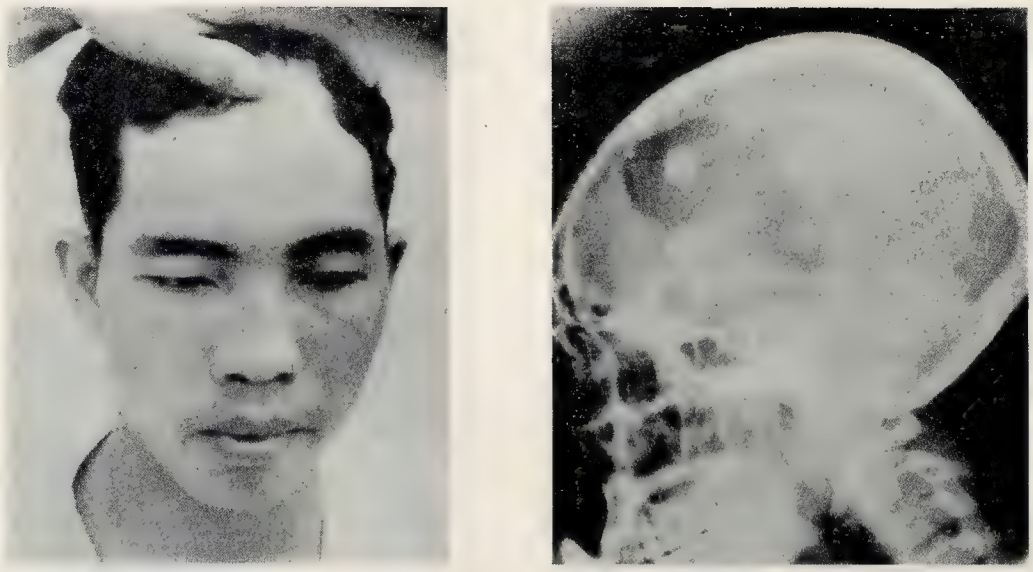


Fig. 57. Case 45. Severe burn over his neck and both hands. After capture, he was forced to be tattooed with anti-Communist slogans on his left arm. During forcible "screening," when the captive again insisted on returning to his mother-country, the American military personnel cut off the part of the left arm bearing the tattoo marks without anesthesia in full sight of his fellow prisoners. Photo showing the big scar over the left arm.



A B

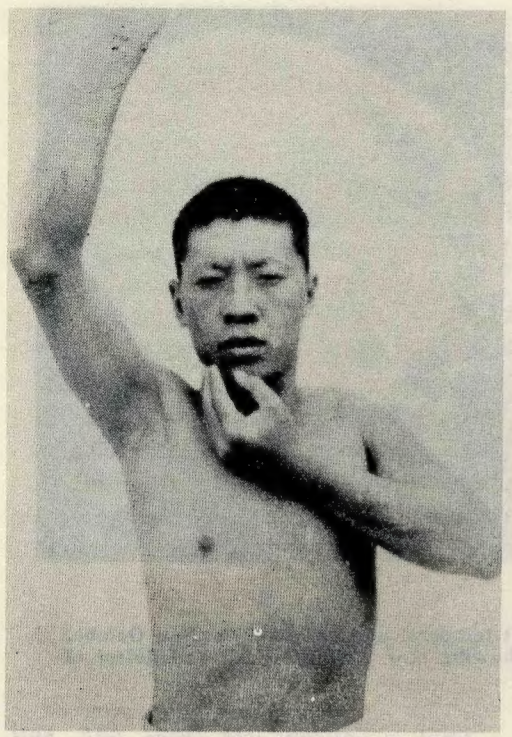
Fig. 58. Case 46. Gunshot fractures of the left temporal and parietal bones on October 1, 1952. Photo and roentgenogram showing scar over the head and defect of the left temporal and parietal bones.

ILLUSTRATIVE CASE 47: RECORD No. 114, CHANG KUO-TUNG, I.S.N. 708313. Received gunshot wound over his left shoulder region, resulting in fractures of the left humerus and the left scapula. Presently the function of his left shoulder joint is entirely lost (Figs. 59A, 59B and 59C).

Fig. 59A Case 47. Roentgenogram reveals old fractures of the left humerus and scapula.

e. *Violence committed by American army medical personnel.* If we accept the principle that the task of a military medical man is to treat humanely the sick and the wounded, then what they actually did was quite to the contrary. They chose to become the accomplices of their military in inflicting bodily injuries on the sick and wounded in their charge.

ILLUSTRATIVE CASE 48: RECORD No. 27, WANG K'UN, I.S.N. 712299. Sustained compound fractures of the lower third of both bones of his right leg, following shell wound, on May 18, 1951. Three days, later, he was captured. He was carried away to the foot of a hill shortly after the capture. He was interrogated by the American military together with their military surgeons and they tried to force him to disclose military secrets. They threatened him by saying, "If you don't tell the truth, we shall cut off your leg immediately." He did not yield and immediately the American military surgeons started to work by first applying a rubber tourniquet over the upper part of his right



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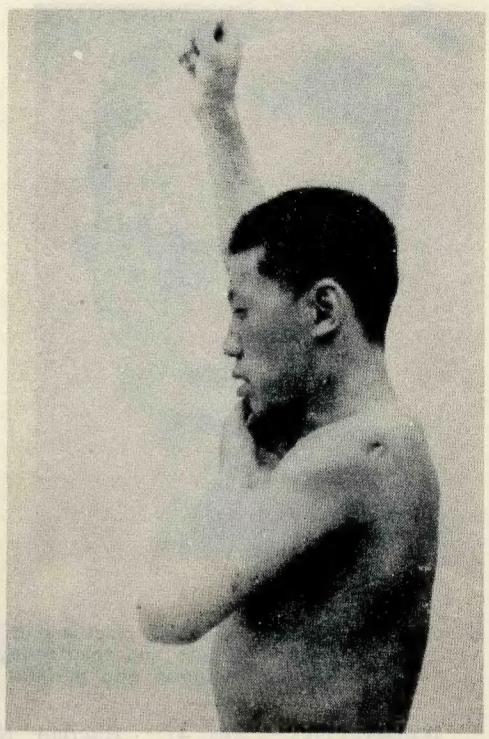

C

Figs. 59B and 59C. Case 47. Gunshot injury of left shoulder region with fractures of the left humerus and the left scapula. Photos showing total loss of function of the left shoulder joint.

thigh. They were helped by three military personnel who firmly grasped his legs and arms. No anesthesia was given, no antiseptic was applied, and the cuttings were started. At each stroke they would stop and question him more. Some of the questions which the patient can still remember were: "Where are your headquarters?", "Are you a Communist Party member?", and "What type of guns have you?".

Thus, after several cuts, the torture being too much for him to bear, he fainted and soon lost his consciousness. When he came to, he noticed that his right leg had already been amputated above the knee. Thereafter, he was sent to the Pusan Base Hospital where re-amputations at higher levels of his right thigh were done twice (Fig. 60).

Fig. 60. Case 48. Compound fractures of the lower third of both bones of right leg. After capture, the American military surgeons assisted in forced interrogation by cutting off his right leg without anesthesia.

Comment: The case reported above presents a most ugly picture of a group of

American military surgeons who violated the ethics of their calling and tried to force confession by torturing a wounded P.O.W. This is indeed a shameless and inhuman conduct.

Recapitulation

The cruelty of American troops in manhandling and brutally treating utterly unarmed captives is truly horrible to relate. Evidences of disfiguring, disabilities and other consequences of such violence are still extant. Before these facts, the American aggressors will find no excuse for their barbarities.

What is more appalling is the fact that American army medical personnel, whose task it is to heal the sick and wounded, became accomplices of their military in assisting in the forcible interrogation and detention of P.O.W.s, and, worst of all, in actually helping in torturing the sick and wounded. This is not only a serious breach of the Geneva Conventions, but also it degrades the noble profession of medicine. We appeal to the righteous medical workers of the world for justice. We renounce and protest against such acts of villainy.

CHAPTER X

CONCLUSION

We have examined a total of 1,609 returned sick and wounded prisoners of war and have made special investigations of their medical and surgical conditions. On the basis of humanitarianism and medical ethics we have analysed the pertinent data and have come to the following conclusions.

In the treatment of war wounds, one of the most outstanding features is that extremities of the wounded were intentionally sacrificed by unreasonable amputations and amputations at high levels. Fresh wounds were not treated in time by debridement. Wounded P.O.W.s with fractured bones had no transportation fixation. In the base hospital, no attempt was made at reduction of fractures and proper method of immobilization was not employed. Operations were done without proper indication, and precaution for prevention of deformities was not considered. In the treatment of other war injuries such as those of the eye, no timely therapy was prescribed to lessen the patient's suffering and to prevent sequelae of the injury. These criminal practices undoubtedly caused a large number of cases of disablement. As to instances of procrastination in treatment and lack of nursing care, they are too numerous to mention. Such malpractices as these have not only violated the basic principles in the treatment of war wounds, but also the spirit of humanitarianism.

Further, among 567 medical cases 92 per cent are with chronic respiratory diseases. Seventy-one per cent of the patients with pulmonary tuberculosis have active lesions, and about 90 per cent of those who have non-tuberculous respiratory conditions still complain of symptoms referable to the chest. These are indeed startling figures. In practically all these cases, the initiation and aggravation of disease could be directly or indirectly traced back to atrocities or horrible living conditions in the P.O.W. camps.

These sick prisoners were given no special consideration by the U.S. camp authorities. Diagnosis was delayed or erroneous. Treatment was irrational or was not given. All captured personnel of our side, ailing prisoners of war not excepted, were subjected to physical and mental tortures, including poison gas attacks. The food they ate was so much below the minimal requirement as to have resulted in an extraordinarily high percentage of deficiency diseases even in those who were not sick or wounded—a factor which certainly played an important part in the etiology of the widespread respiratory infections. The so-called infirmaries were in reality concentration camps where patients were indiscriminately thrown together with no care, practically no treatment, no isolation precautions. Under these appalling circumstances, it is no wonder that so many either perished or developed chronic diseases.

We are thus eye-witnesses of the mutilations, devastating diseases and disabilities suffered by our returned P.O.W.s.

The details herein given are evidences that the U.S. armed forces in Korea have committed atrocities on sick and wounded P.O.W.s and have violated the Geneva Conventions of August 12, 1949. In the name of humanity and medical ethics we have the responsibility to indict the U.S. armed forces for their foul crimes and make known to the world the facts as presented in this Report.

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